DOCUMENT RESUME

ED 343 670 PS 020 363

AUTHOR Hansen, Kirsten A.; Martner, Janet S.
TITLE Mental Health in Head Start: A Wellness Approach.
INSTITUTION Georgetown Univ. Child Development Center, Washington, DC.
SPONS AGENCY Administration for Children, Youth, and Families (DHHS), Washington, DC. Head Start Bureau.; Health Resources and Services Administration (DHHS/PHS), Rockville, MD. Office for Maternal and Child Health Services.
PUB DATE 90
CONTRACT MCJ-0113806-03
NOTE 180p.
PUB TYPE Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC08 Plus Postage.
DESCRIPTORS *Child Health; Comprehensive Programs; *Early Intervention; Educational Diagnosis; *Holistic Approach; Mental Disorders; *Mental Health; *Mental Health Programs; Parents; Preschool Education; Prevention; Program Administration; School Personnel
IDENTIFIERS *Project Head Start; *Wellness

ABSTRACT

Designed to help Head Start mental health coordinators incorporate mental health into all aspects of the program, this manual describes planning strategies, suggests activities, includes samples of forms successfully used by other programs, and lists resources. Part I discusses the meaning of mental health and shows the relationship between a holistic mental health approach and the Head Start model. Three levels of intervention (prevention, identification and referral, and treatment) are described and discussed in relation to the mental health of program staff and administrators, parents, and children. Part II focuses on the roles and responsibilities of the mental health coordinator and professional. This section considers the professional competencies and personal characteristics needed by mental health professionals; describes several possible staffing models; and offers information on the various mental health problems Head Start staff may encounter. Part III presents a process for developing a mental health plan that includes five steps: (1) establish a philosophy; (2) gather information; (3) develop the plan, including goals, performance standards, activities, timelines, and documentation procedures; (4) implement the plan; and (5) evaluate the plan. Each part of the text concludes with sample forms, instructions for activities, guidelines, and information sheets. Appendixes contain Head Start Mental Health Program and other relevant performance standards; a 102-item bibliography; and a list of useful journals and organizations. (AC)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Human Development Services
Administration for Children, Youth and Families
Head Start Bureau

Mental Health in Head Start:

A Wellness Approach

This publication was prepared pursuant to Grant No. MCJ 0113806-03 from the Public Health Service as part of an Intra-Agency Agreement between the Administration for Children, Youth and Families and the Maternal and Child Health Bureau. Grantees and contractors undertaking such projects under government sponsorship are encouraged to express freely their judgment in professional and technical matters. Points of view or opinion, therefore, do not necessarily represent official Office of Human Development Services policy or positions.

MENTAL HEALTH IN HEAD START:

A WELLNESS APPROACH

Written by:

Kirsten A. Hansen, M.Ed.
Project Director

with

Janet S. Martner, M.S.W.

Georgetown University
Child Development Center
Head Start Mental Health Project

TABLE OF CONTENTS

ACKNOWLEDGMENTS

Many people contributed their ideas, enthusiasm, and support to the creation of this manual. We would like to thank the Head Start Bureau and Wade F. Horn, Commissioner, for recognizing the need to highlight the importance of mental health in Head Start. Clennie H. Murphy, Jr., Associate Commissioner of the Head Start Bureau, put in motion the process to develop this much needed document through the Public Health Service. Other Head Start Bureau staff we wish to recognize include Marlys Gustafson, Merrily Beyreuther, Dollie Wolverton, Jane DeWeerd, Rick Johnson, and Rossie Kelly. We appreciate their on-going support. Mary S. Lewis and Hector Sanchez also have been major leaders in bringing mental health issues to the forefront of Head Start. Finally, strong encouragement and support has come from the Office of Human Development Services Regional Offices. We appreciate the continued direction and caring oversight they give to the total Head Start program.

Special recognition goes to Phyllis E. Stubbs, M.D., Chief of the Early Childhood Health Branch of the Maternal and Child Health Bureau, for her guidance, support, and dedication to strengthening mental health in Head Start. Howard W. Kroll, Ph.D., Mental Health Specialist, is a tireless advocate for the importance of mental health in Head Start and has built the Public Health Service Mental Health training and technical assistance network. His support and interest in this project has been unwavering. The Public Health Service (PHS)/Head Start staff in the PHS Regional Offices offered us a strong network within which to banter ideas, conceptualize approaches, and advocate for strong prevention programs.

Special acknowledgment goes to Jan Martner, M.S.W., who served as the Project Coordinator of the Georgetown Head Start Mental Health Project during the conceptualization and development of the first draft of this manual. Although the manual has been through many changes, her ideas and vision of the contents are an integral part of this final product. Her hard work, dedication, knowledge of Head Start needs, and careful thought are truly appreciated.

Fond appreciation goes to Phyllis R. Magrab, Ph.D., Director of the Georgetown University Child Development Center, for her continued guidance, humor, judgment, and perception throughout this project.

The following individuals significantly contributed to the development of this manual by serving on the Materials Development Team. Their ideas, interest, and dedication to mental health in Head Start are truly appreciated.

- Deborah Booth, M.Ed., Special Projects Manager, East Coast Migrant Head Start Project, Chapel Hill, North Carolina
- Elena Cohen, M.S.W., Project Director, Early Intervention Project, Washington, D.C.
- Emily Jenkins, B.A., Mental Health Specialist, Human Development Corporation/Head Start, St. Louis, Missouri

- Howard W. Kroll, Ph.D., Mental Health Specialist, Public Health Service, Rockville, Maryland

- Walter Lauterbach, Ph.D., Regional Mental Health Coordinator, Public Health Service, Philadelphia, Pennsylvania

- Mary S. Lewis, Ph.D., Education Specialist, Head Start Bureau, Washington, D.C.

- Sally Self, B.S., Health/Handicap Coordinator, Arlington Community Action Program, Inc./Head Start, Arlington, Virginia

- Lee Taylor, M.B.A., Executive Director, Tri-County Head Start, Durango, Colorado

Special thanks goes to the Head Start Mental Health Advisory Committee who inspired, guided, and assisted us with our tasks. Many of these people have contributed their expertise to Head Start for years and we appreciate their continued support. The members of this committee include: Cynthia D. Barnes, M.D., Michael E. Fishman, M.D., Edmund W. Gordon, Ed.D., Mary S. Lewis, Ph.D., Phyllis R. Magrab, Ph.D., Sally Provence, M.D., Lavolia P. Mack-Miller, L.C.S.W., Clennie H. Murphy, Jr., M.S., Alberto Serrano, M.D., Nancy Stone, M.D., Phyllis E. Stubbs, M.D., Helen H. Taylor, M.A., and Paul D. Vander Velde, M.S.

The Resource Access Projects and Regional Resource Centers of the Head Start training and technical assistance network supplied us with materials, enthusiasm, and space in their training conferences to test our ideas. They offered us their full support for this project.

Throughout the planning and development process we were encouraged not to "reinvent the wheel," but to use information and manuals previously produced for Head Start in the area of mental health. Heartfelt thanks goes to the authors of the manuals listed below for their words and ideas which paved the way for this project:

Cook, K., & Retzer, S. (1987). *Project Bridge: A cross-cultural approach to mental health in Head Start.* Unpublished material.

Hagenstein, A., & Antes, M. (1986). *Management action plan: A blueprint for Head Start coordinators.* Newton, MA: Education Development Center, Inc.

Hawks, D. (1978). *The mental health consultant for Head Start* (2nd ed.). College Park, MD: University of Maryland College Center for Professional Development.

Office of Human Development Services. (1986). *A guide for education coordinators in Head Start* (DHHS Publication No. [OHDS] 86-31536). Washington, DC: U.S. Government Printing Office.

Office of Human Development Services. (1987). *Head Start health services, health coordination manual* (DHHS Publication No. [OHDS] 84-31190). Washington, DC: U.S. Government Printing Office.

Riley, M.T., Bucher, M., Price, J., & Tidwell, T. (1984). *Integrating mental health into Head Start: Reinforcement booklet.* Lubbock, TX: Texas Tech University.

Seabolt, N. (1979). *Mental health services in Head Start: A guide to implementing the mental health objectives and performance standards.* Kansas City, MO: Community Development Institute.

Stone, N., Pendleton, V., & Vaill, M. (1981). *Head Start mental health manuals.* (Vols. 1 & 2). Unpublished material.

Special recognition and appreciation go to the thousands of Head Start staff members who provided a wealth of knowledge and unique perspectives on program operations. Their inspiration and dedication to their work as well as to the parents and children in their programs impressed and motivated us.

Finally, we would like to thank the people behind the scenes who supported us with their talents, patience, and humor. Marie Keefe and Cappie Morgan, our editors, kept us focused and provided unending, useful suggestions and ideas. Debbie Waring, our word processor, provided expertise, an outside eye, and patience with our many changes.

INTRODUCTION

Head Start is an action-oriented, proactive, "we can make a difference" program and you, in your role as mental health coordinator, play a vital role. Currently, the mental health portion of the program is in the spotlight as the Head Start Bureau, the Public Health Service (PHS), Administration for Children, Youth and Families (ACYF) Regional Offices, and your colleagues team up to create solutions, confront challenges, and develop creative programs which can nurture the mental wellness and health of the Head Start staff, parents, and children throughout the country.

As mental health coordinator, you share this meaningful initiative. You have the opportunity to lead your program and work beside your colleagues to navigate uncharted waters, discover new ways to meet challenges, and facilitate the assimilation of good mental health practices throughout your agency. To accomplish this task you need *energy* and the ability to *encourage* and *enable* the staff, parents, and community members to envision and create the course for your community. These are the three "E's" of a mental health coordinator in Head Start.

Why Read This Manual?

This manual is designed to assist you in creating a program that meets your needs. It offers information on the complexities of mental health in Head Start and describes planning strategies, suggests activities, gives examples of situations, includes samples of forms successfully utilized by other programs, and lists resources. Consider this information, mold it to fit your program's unique needs, and create a mental health plan which makes a difference in your community.

The specific objectives of the manual are to:

- Provide guidance to the designated Head Start Mental Health Coordinator in understanding the scope of mental health in Head Start.
- Clarify the roles and responsibilities of the mental health coordinator and the mental health professional and demonstrate the way they relate to other component coordinators.
- Provide assistance in planning a program which incorporates mental health into all Head Start components and includes staff, parents, and children.
- Provide the Head Start Director and administrative staff with an overview of the scope of mental health in the Head Start program.
- Provide resource materials including forms, contracts, written materials, and lists of organizations which have been recommended as useful.

How to Use This Manual

This manual is designed to be used in conjunction with the Head Start Program Performance Standards, policy manuals, *Health Coordination Manual*, and other documents published by the Administration for Children, Youth and Families, and with local program policies and procedures.

The manual is divided into three parts:

- Part I: Mental Health and Head Start: A Perfect Fit
- Part II: Mental Health Is Everybody's Business
- Part III: Five-Step Process for Planning the Mental Health Program

Part I discusses the meaning of mental health and shows the relationship between a holistic mental health approach and the Head Start model. Part II provides an in-depth discussion of the roles and responsibilities of the mental health coordinator and professional. Part III provides a five-step process for developing a mental health plan.

At the end of each part is a section called *SAMPLES*. This section contains forms which have been successfully used by Head Start grantees. These forms can be copied and/or adapted to fit your program's needs. Additional information is also located in *SAMPLES*. For example, when we discuss the need for training in Part II, there are references in the text for additional training ideas and formats which are located in the Part II *SAMPLES*. Following each section of *SAMPLES* is a list of the references used in each part.

The appendices are located at the end of the manual. They contain:

- A. Head Start Mental Health Program Performance Standards
- B. A list of other component program performance standards which relate to mental health
- C. A Reference Bibliography which is divided into the areas of Prevention, Identification and Referral, Treatment, and Books for Children
- D. A list of useful Journals and Organizations

In addition to the information in this manual, mental health coordinators are encouraged to contact their regional ACYF offices, Public Health Service (PHS) staff, Resource Access Projects (RAPs), and Regional Resource Centers (RCs) for further resources and assistance.

PART I
MENTAL HEALTH AND HEAD START: A PERFECT FIT

Mental health in its simplest form is the capacity to:

Love

Work

Play

All people need to feel that they have:

- The ability to form meaningful relationships and have positive self-esteem.
- The ability to be and feel productive and know that they contribute to society.
- The ability to play, relax, and use leisure time in a manner which renews energy.

To be mentally healthy is to get the most out of life; this requires knowledge (lifelong learning), appropriate social behavior, and good personal health (physical, dental, and nutritional). In another sense, mental health is the capacity to cope with all of life's circumstances, the highs and the lows, and the joys and the sorrows. We all experience good days and bad days; the difference is how we get through them and our ability to continue building successful life management skills.

Unfortunately, "mental health" is a term that often brings to mind mental illness. Nightly, the media focus on people with serious mental health needs. The average mentally healthy person does not make the lead story. Drugs, alcohol, violent and non-violent crime have become more and more a part of our life. It must be remembered that mental health is a continuum which stretches from the mental illness end, where people are in need of intervention and treatment services all the way to the wellness end, where individuals are healthy and productive, managing life with energy and skill. In between the two ends of the continuum are the majority of people who live their lives as well as they can and either continue to learn positive life-management skills or slide towards more negative mental health practices.

The problems and concerns of Head Start families are those of society. Head Start families are facing extreme stressors. To begin with, the majority live in poverty. Added to that is a large percentage of foreign-born families who do not know the language and customs of this country. Most households are headed by single parents. Head Start staff must continue to learn ways of helping Head Start families address these challenging situations.

Fortunately, many agencies are working on solutions to these complex issues. While the major problems of Head Start families will not be fixed during the course of a Head Start program, as the mental heath coordinator you have the opportunity to influence how these issues are dealt with. A strong, concrete prevention program educates staff, parents, and children and allows them to practice new-found skills and receive support. You can also provide identification, referral, and treatment services to those in immediate need.

As a society, as well as in Head Start, our intention is to provide services and support to assist and educate citizens to move towards the happy, productive end of the mental health continuum.

HOW DO HEAD START AND MENTAL HEALTH FIT TOGETHER?

"The overall goal of the Head Start program is to bring about a greater degree of social competence in children of low income families. By social competence it is meant the child's everyday effectiveness in dealing with both present environment and later responsibilities in school and life. Social competence takes into account the interrelatedness of cognitive and intellectual development, physical and mental health, nutritional needs, and other factors that enable a developmental approach to helping children achieve social competence." Performance Standard (P.S.) 1304.1-3(b)

The program area now known as mental health has gone through several changes in philosophy, goals, and services since its inception. In the first Head Start programs, the area was entitled Psychological Services. It provided direct services which included evaluation and treatment of Head Start children and their parents. In 1973 the philosophy and name changed to Mental Health. This change was designed to reflect the contribution of a variety of mental health professionals such as psychiatrists, psychologists, and social workers to Head Start programs. It also provided for mental health to be part of all component areas and placed the primary emphasis on prevention activities rather than treatment activities.

Recently, the mental health area has moved to the foreground of the Head Start program. More and more people are realizing that mental health intertwines with every aspect of the program and affects every participant from administrator to staff, to parent, to child, and on to the community. Understanding the meaning of mental health and converting that understanding into program philosophy, objectives, and activities is imperative if you are going to effect change in Head Start families.

A HOLISTIC APPROACH TO MENTAL HEALTH

To approach mental health from a positive perspective, it is helpful to think in terms of wellness, which is best promoted by a holistic approach. A holistic approach addresses all of an individual's needs: physical, emotional, social, cognitive, occupational, and spiritual.

The *physical* aspects of mental health include:	• Physical health • Good nutrition habits • Fitness and exercise • Dental health
The *emotional* aspects encompass:	• How we feel • How we express our feelings • Our ability to solve problems • Our ability to love • Our ability to cope with stress • Our ability to challenge ourselves • Our ability to master negative emotions (anger, jealousy)
The *social* aspects include our ability to:	• Form meaningful relationships • Develop our interpersonal skills • Make and keep friends • Behave in socially acceptable ways
The *cognitive* area involves:	• Development of the intellect • The ability to learn new skills • Curiosity and an interest in learning • Problem-solving skills • The ability to learn how to get new information
The *occupational* aspects allow us to:	• Develop our productivity so contributions can be made to community and society • Qualify for better paying, more satisfying work
The *spiritual* aspect provides:	• Internal guides for living

The Head Start program is a comprehensive model of services comprised of four major components: Education, Social Services, Parent Involvement, and Health (medical, dental, nutrition, and mental health). If you compare these components with the holistic approach, you will see that the design of Head Start provides components to support each facet of wellness.

HEAD START COMPONENTS SUPPORT WELLNESS

Holistic Approach to Mental Health	Head Start Component
Physical	Medical, Dental, Nutrition
Emotional	Mental Health
Social	Social Services/Parent Involvement
Intellectual	Education
Occupational	Parent Involvement/Social Services
Spiritual	A basic tenet of Head Start is the support and respect for individual differences which cross all components

As the holistic approach to mental health is a fully integrated one, so, too, is Head Start's. By considering each person as a whole and appreciating that mental health is related to each part of the whole, you can readily grasp the need to incorporate mental health into the entire Head Start program operation. Mental health activities are vital to each component, consequently, every staff member within each component has the responsibility to promote and plan them. The mental health coordinator helps out by interacting with all the component coordinators to support such practices. The old saying, "An ounce of prevention is worth a pound of cure," certainly could be the motto of Head Start and the mental health coordinator. If you can promote practices within each component area to nurture mentally healthy children, parents, and staff, all of them can be better able to meet the challenges that await them. It is simply more effective for your program to have a prevention emphasis and strengthen each individual than to identify and treat deficits.

Head Start, through its innovative and comprehensive approach to the total needs of families, can promote positive mental health practices and, therefore, enhance the self-esteem, self-sufficiency, and independence of Head Start staff, parents, and children.

MENTAL HEALTH PERFORMANCE OBJECTIVES

Head Start is guided by a set of approved program performance standards which mandate minimum compliance. These standards were written for each component and should be available from the program director or the ACYF regional office. The Mental Health Performance Standards, which are part of the Health Standards, appear in their entirety in Appendix A.

Each section of the standards begins with a list of objectives which serve as guidelines for designing and developing a program to meet the needs of an individual community. Following the objectives is a list of standards with guidance to give programs ideas on how to follow the standards.

The mental health standards require that a mental health professional be available to Head Start to perform certain clearly specified functions and activities. The standards also outline activities which may be performed by a coordinator. In Part II: Mental Health is Everybody's Business, the section on the mental health professional lays out those performance standards and provides parameters for this vital job. Since Head Start's comprehensive model reflects a holistic approach, it is logical that many of the performance standards in other components relate to mental health as well. Cross-component integration and collaboration are also discussed. A list of related performance standards is in Appendix B.

Performance Standard 1304.3-7 (a-f) (Appendix A) describes the formal objectives which every Head Start program must strive for in the area of mental health. Because these objectives and required standards are so flexible, you can create a plan for service delivery tailored to the needs of your community and its resources.

THREE LEVELS OF INTERVENTION

The mental health objectives are grouped in this manual according to three levels of intervention. The three levels are: Prevention; Identification and Referral; and Treatment. While identification, referral, and treatment are interventions conducted within Head Start, the program's primary focus should be prevention. These three levels provide you with a framework within which to conceptualize your individual mental health program. They will be utilized as organizational reference points throughout this manual.

Prevention activities are designed to help staff, children, and their families learn and practice skills which may help them remain healthy. Some of the goals of a prevention program are to improve self-concept; build positive relationships among children, their peers, and their caregivers; develop coping skills to problem-solve; and manage stress.

Identification and Referral focuses on early detection of problems of staff, children, and parents who may be in need of mental health services. Services to children and families may include: identification of possible problems through observation, screening, and assessment. If needed, referral and indicated treatment can begin as soon as possible with Head Start staff supporting the process and following up in a confidential manner.

Treatment is suggested if a portion of the assessment process demonstrates that staff, children, and/or parents could benefit from a treatment process. Depending on the individual's needs, a plan may be developed collaboratively with the Head Start mental health professional, Head Start personnel, and the family. Head Start staff can then offer confidential support.

This section is adopted from *Mental Health Services in Head Start: A Guide to Implementing the Mental Health Objectives and Performance Standards.* It lists the mental health objectives (Performance Standard 1304.3-7 (a-f)) by level of intervention.

Prevention Objectives

Assist all children participating in the program in emotional, cognitive, and social development toward the overall goal of social competence in coordination with the education program and other related component activities.

Possible Implementation: Training for staff on social-emotional growth; activities which encourage self-expression and independence; information on prevention curriculums; information for staff and parents regarding children with disabilities.

Provide staff and parents with an understanding of child growth and development, an appreciation of individual differences, and the need for a supportive environment.

Possible Implementation: Observation in the classroom and other programs; support group discussions; lending library of toys and information; cultural and ethnic activities; training on developmentally appropriate expectations.

Develop a positive attitude toward mental health services and a recognition of the contribution of psychology, medicine, social services, education, and other disciplines to the mental health program.

Possible Implementation: Training and in-service on roles and responsibilities within all components; information on a holistic approach to mental health; discussion of the role of the mental health professional.

Identification/Referral Objectives

Provide for prevention, early identification, and intervention in problems that may interfere with a child's development.

Possible Implementation: Information and training on screening tools; training on the role of mental health professional and disabilities coordinator; observation techniques.

Mobilize community resources to serve children with problems that prevent them from coping with their environment.

Possible Implementation: Training for teachers and staff on communication techniques such as how to talk to parents about mental health; information on referral process and observation techniques.

Treatment Objectives

Provide children who have disabilities with the mental health services they require.

Possible Implementation: Training for staff on mainstreaming and social integration techniques; time for mental health professionals and teacher/parents to discuss child's emotional needs (Seabolt, 1979).

Due to the interactive nature of the Head Start program, it is obvious that children benefit when the other participants in the program -- staff and parents -- are mentally healthy. Many Head Start programs, while offering excellent support for children, have not emphasized the importance of developing a nurturing, proactive mental health program for the staff and parents.

Because the mental wellness of these two groups is essential, this manual sets out specific mental health objectives for staff and parents, as well as for children. These objectives are divided into the three intervention levels: prevention, identification and referral, and treatment, and are paired with suggested activities to assist you in planning ways to meet the mental health needs of all involved with your program.

STAFF/ADMINISTRATOR'S MENTAL HEALTH

PREVENTION

Administrators set policy and procedures, hold and facilitate meetings, and supervise staff. Through their leadership and management style, all these people are in the position to promote or to diminish the value of mental health practices. Agencies which hold positive mental health practices as being important usually have policies that provide staff with opportunities for support, enrichment, and fun.

PREVENTION OBJECTIVES	SUGGESTED ACTIVITIES FOR STAFF
To work in an environment which supports communication.	• Weekly "Let's Discuss It" meetings. • Director's open-door policy. • Well-written rules, regulations, and procedures. • Clear lines of communication. • System of grievance procedures. • Fair evaluation process. • Support groups led by mental health professionals.
To feel acknowledged.	• Secret pal systems. • Retreats. • Letters of commendation placed in personnel files. • Personal notes to staff from supervisors. • Articles in local newspapers. • Acknowledgment events and bulletin boards. • Surprise luncheons. • A conscious commitment to verbally reinforce good work. • Career development.
To take responsibility for promoting good mental health practices.	• Training on: - signs and symptoms of mental health problems - communication - health/stress - conflict resolution - burnout • Information on community resources.
To understand and respect cultural differences among staff.	• Participant oriented training sessions. • Parties and cultural events. • Informal talks by parents and community members. • Written or visual resources.
To receive relief from stress and tension.	• Walking clubs. • Exercise classes. • Staff development/support groups. • Promotion of listening skills. • Activities for fun: - Parties-surprise birthday lunches - Posting cartoons and sending funny notes.

IDENTIFICATION AND REFERRAL

As we have emphasized, staff who are not mentally healthy may not be able to encourage good mental health practices in the other staff, parents, and children with whom they work. Many people at certain times during their lives need mental health services and their work settings should be supportive during those times. It is important that Head Start programs have a mechanism for identifying staff who may be in need of mental health services and strategies for assisting them.

Objectives

Staff need:

- To feel comfortable asking for and receiving assistance as needed.
- To be aware of warning signs which signal that someone is in need of assistance; to know how and where to refer this person.

Suggested Activities for Staff/Administrators

Employee Assistance Program. Many Head Start grantees have developed their own employee assistance programs. All Head Start employees may go to the program coordinator, discuss their problems and begin working on a solution. Supervisors also may refer employees to the assistance program. Head Start assists them in securing the help they need and may refer them to an outside agency such as Alcoholics Anonymous, a community mental health center, or a drug counseling center.

Information. All staff should be provided information on drug abuse, alcohol abuse, depression, low self-esteem, and other indicators of mental health problems. (See Part II: Mental Health is Everybody's Business for specific information.)

When staff notice a change of behavior in another, they should express this concern directly to that person if their relationship permits it. When this is not possible, it is important that the concern be mentioned to someone in a position to help. When staff do not receive help in solving their problems, it is a disservice to the Head Start children and their families.

Counseling and Therapy. Some Head Start grantees use a portion of the mental health professional's time to provide counseling to employees, usually for two or three sessions. If more extensive assistance is needed, the professional would refer them to another resource.

Support Groups. Some grantees use mental health monies to form staff support groups. These groups are led by the mental health professional and allow staff to discuss problems and issues. If there is a need for more intense or longer-term assistance, referrals are made to an outside agency.

TREATMENT

Head Start provides very little in the way of direct, long-term mental health services to staff, children, or parents. The role of Head Start in the treatment process is to follow up on services, support the individual, and continue to provide the full range of Head Start activities.

Objective

- To have knowledge of and access to treatment services.

Suggested Activities for Staff/Administrators

If a staff member is in treatment, Head Start should be as supportive and flexible as possible in order to enable the person to both receive treatment and still fulfill work obligations. In all cases, the utmost care must be taken to provide confidentiality of information regarding identification, referral, and treatment of children, staff, or parents.

PARENTS' MENTAL HEALTH

PREVENTION

Parents are active participants in Head Start and benefit from a mental health program which promotes wellness in a multitude of ways. A significant benefit is derived through their interactions with staff as they observe modeling of positive mental health skills. A good program will ensure that the staff's approach to parents is supportive, encourages independence, and is respectful of cultural, language, and individual differences.

Specially designed training sessions and volunteer opportunities will offer parents information and skills which can promote good mental health for themselves and their families. A preventive program for parents provides opportunities for them to contribute their ideas and talents while at the same time receiving support.

PREVENTION OBJECTIVES	SUGGESTED ACTIVITIES FOR PARENTS
To feel acknowledged and supported in the parenting role.	• Encouraging parents to send notes to the teacher describing child's accomplishments. • Concrete, participant oriented classes on child growth and development which acknowledge the good job parents are doing. • Asking parents what they think and want. • Listening to parents. • Thank you's when parents help in program. • Special events that are fun -- trips, parties, retreats. • See SAMPLES for more Parent Group Activities.
To promote good mental health practices.	• Orientation and ongoing training sessions on mental health practices. • Discussion and support groups led by mental health professionals. • Good staff modeling. • Reinforcement for practicing new skills.
To receive acknowledgment for their contributions.	• Notes of appreciation. • Payment for services. • Appreciation events and parties. • Public acknowledgment in meetings, newspaper articles. • Surprise parties or fun events.
To enhance self-respect.	• Self-esteem classes. • Career development. • Child Development Associate (CDA) or General Education Degree (GED) classes. • Direct involvement in decision-making processes. • Events which feature their culture and customs. • Finding and using available resources. • Classes -- exercise, sewing, walking, canning, budgeting.

IDENTIFICATION AND REFERRAL

The Social Services Performance Standards (1304.4-2) clearly state that social services is responsible for providing appropriate counseling for parents. Any one of the Head Start staff may notice changes in the behavior of parents; the cook, who has coffee with the parent, may be concerned and want to pass the information on. Consequently, all staff should have some general information regarding mental health so they can be aware of possible problems. Policies and procedures must be in place and clearly understood, so staff know exactly who to voice their concerns to in an appropriate and confidential manner. Concerns for parent mental health appear in family needs assessments, parent reports, medical records, children's behavior, and word of mouth.

Objectives

- To feel comfortable asking for and receiving assistance as needed.
- To expect staff to approach referrals in a sensitive, timely manner.

Suggested Activities for Parents

Support Groups. Some grantees employ a mental health professional to lead support groups where parents can discuss their problems and concerns as well as receive help from other parents and a mental health professional. If concerns arise, the parent may be referred to a community agency for further assistance.

Discussions with Parents. In many programs, the mental health professional talks over problems with parents and, if necessary, helps them seek assistance. For example, if a parent suddenly stops sending the child to school and does not contact the program, the staff would become concerned. After talking to the parents, they may discover that the family is having a financial crisis and needs to see a budget specialist or they may be suffering severe depression and not be able to make appropriate decisions. Then, referral to the community mental health agency would be logical. In both cases, Head Start would provide follow-up service and support. (See *SAMPLES* for *Mental Health Referral Guidelines.*)

TREATMENT

Head Start provides very little in direct treatment services to families. In some programs, the mental health professional can provide two or three sessions of therapy for a family and then follow up with support when they are referred to a community resource. All records and documentation regarding treatment plans or processes are confidential.

CHILDREN'S MENTAL HEALTH

PREVENTION

Activities to promote mental wellness and good early childhood practices are one and the same thing. They are exhibited in four categories.

Environment -- Create an environment that allows for comfortable learning. Things to be aware of include:

- Presence of soft things (grass, pillows, laps, soap suds)
- Awareness of colors and how they affect mood
- Noise volume - this influences concentration, anxiety level, and creativity
- Structured versus unstructured environment
- General comfort of adults and children
- Open discussion and communication

Arrangement of the Classroom/Home -- Arrange the environment to manage behavior and build confidence. Be aware of:

- The number of rules
- Effective scheduling - reduce waiting time
- Group size - children learn better in small groups
- Storage of materials - visible and accessible
- Personal space - have space for personal items

Daily activities planned for the classroom -- Make sure the day-to-day activities planned promote good mental health practices. The important outcome of any activity is that the children feel good about their ability *to* learn, not necessarily *what* they learned. Be sure to think about the goals, the values being promoted, and the feelings that will result from the activity.

Activities that specifically address mental health issues -- There are many activities which can be designed to address mental health issues. The *AS I AM* curriculum which is distributed by the Head Start Bureau provides many good activities. It is important to plan specific activities in the area of mental health just as it is for other areas of development. See the *SAMPLES* section for a list of activity suggestions.

We encourage the teaching team to have a section in their lesson plan which lists "Mental Health Activities." This strategy is two-fold: First, it ensures that mental health will be addressed in a specific manner each day, and, second, the words in the lesson will serve as a reminder to parents and other volunteers in the classroom and help them to understand what mental health means.

Building self-esteem is the cornerstone of the prevention program. How we feel about ourselves is one of the most important factors in dealing with daily living and the stress it produces. We view our experiences and perceptions of others through our image of ourselves. If the image is negative, or if someone loved and respected (teachers, parents,

caregivers) gives negative messages such as "you can't," or "you are dumb," or "you have funny customs," the effect may be a negative self-concept. During the preschool years it is imperative that everything possible be done to build a strong self-concept in children. Their race, language, skills, differences, and family structure must be respected by the staff and acknowledged to the child as something to be proud of.

Prevention activities should also focus on understanding differences. The population of Head Start children is changing rapidly and the number of children and their families from diverse ethnic and cultural backgrounds continues to increase. This makes working in Head Start interesting and challenging; however, it can cause misunderstanding. All of the Head Start component coordinators must find out as much as they can about the language, customs, and culture of the children in their program. Talking to foreign-born parents, reading articles, calling agencies which assist immigrants, and talking to local community leaders will help them to understand the families, and thus plan more appropriately.

Head Start requires that 10 percent of the children enrolled have diagnosed disabilities. As a result, the prevention activities planned for children should include ones that promote an understanding of the strengths and weaknesses of each individual, build friendship skills among children, and explore different types of social integration techniques.

PREVENTION OBJECTIVES	SUGGESTED ACTIVITIES FOR CHILDREN
Assist all children in the program with emotional, cognitive, and social development.	• Listening to children. • Talking to children on their level. • Stress reduction activities -- deep breathing, simple yoga, running, jumping. • Reading aloud: poetry, folktales. • Private spaces for children to be alone. • Taking field trips to see people at work in the community. • Cultural books, dolls, posters, food, and clothing. • For non-English speakers, someone in the classroom who speaks their language. • Providing appropriate ways to display and discuss feelings -- puppets, art (paint, clay), books about feelings or situations.

IDENTIFICATION AND REFERRAL

It is important that children who may be experiencing problems quickly be referred to a mental health professional for a complete assessment and possible treatment. This process must have parent approval. Children are not always capable of talking about their feelings; consequently, these feelings are often expressed through behaviors. Therefore, staff and parents must be aware of signs and symptoms of problems, observe them periodically, and be familiar with the referral process.

Objective

- Ensure prevention and early identification of problems that may interfere with a child's development.

Suggested Activities for Children

There are four primary ways to identify children who may be in need of mental health services. These are: screening, parent report, teacher and/or mental health professional observation, and referral from an outside agency.

Screening. A developmental screening is completed for all children either before they enter the program or shortly after enrollment. This screening identifies children who may be in need of re-screening, further observation, or more extensive testing. The mental health coordinator, the mental health professional, the disabilities coordinator, and the parent involvement coordinator work closely with the parents and staff during this process.

The screening process and the screening instrument you choose will provide basic information about a child's development. Examples of instruments you may want to look at include the Denver Developmental Screening Test (DDST), Developmental Indicators for the Assessment of Learning-Revised (DIAL-R), Early Screening Inventory (ESI), and the Chicago Early Assessment and Remediation Laboratory. There are many instruments to choose from. Each has pros and cons so work with your mental health professional to find an instrument that is age appropriate and fits your population, languages, etc. Call the schools and mental health centers for assistance.

Parent Report. Parent report is another way children are identified as having a potential mental health problem. Since parents spend the most time with their children and know them the best, they have the most accurate information on the "normal" behavior of that child.

Staff should make opportunities to discuss issues with parents. Training for staff on how to discuss mental health issues with parents may be helpful. Allow time during home visits, parent meetings, and on parent volunteer days to talk with parents about their child.

Teacher/Mental Health Professional Observation. Another way to identify potential problems is through systematic classroom observation of the children by the teachers. Most programs also have their mental health professional do general classroom observations throughout the year. There are several observation forms which have been developed specifically to look at mental health issues. Ask your mental health professional for ideas. (Psychological and Social Development of the Child Health Record (Form 9) can be used for observation. This form can be obtained from your ACYF Regional Office. Also see *SAMPLES* for *Classroom Observation Report.*)

If a teacher notices a behavior which she questions, the parents are asked for permission to have a mental health professional observe the child in the classroom. (See *SAMPLES* for *Mental Health Consultation Form.*) If the staff and parents think services may be needed, the child will usually be referred to an outside agency for assessment and possible treatment. (See *SAMPLES* for *Mental Health Referral Forms.*)

Children with disabilities are more at risk for social-emotional problems due to their delay or disability. One of the services provided to children with disabilities is observation for social and emotional problems which they may have developed as a result of their condition. Some of the problems can include not being able to communicate, unable to keep up with their peers, being socially isolated, or not having a good self-concept.

The mental health coordinator, the disabilities coordinator, and the education coordinator will work with the parents and teachers on techniques to assist the child. If the child appears to have a serious problem, the child and family will be referred for assistance to an outside agency. Examples of agencies which may provide services are: community mental health agencies, individual and family therapists who are in private practice, and other community social service agencies. The mental health professional should be able to assist with appropriate resource information. (See *SAMPLES* for *Evaluation/Testing Request* and *Referral to a Mental Health Provider.*)

Head Start staff assist the parent in obtaining the services and provide support during the time services are being received. Staff and parents work together with the agency providing the service to make sure the treatment plan goals and objectives are being met in the Head Start program. For example, if a child is in therapy for being shy and withdrawn, the child's teacher should be aware of specific techniques to use with the child to increase his or her comfort level and interaction in the classroom.

Referral from Outside Agency or Provider. A physician, social service agency, or other provider may indicate to the Head Start program that an enrolled child should be observed because he or she may be "at risk" of mental health problems, in therapy, or have had troubling previous experiences (e.g., a referral from Child Protective Services).

A child who is referred to Head Start by an outside agency will go through the same identification process as anyone in Head Start. The staff will be aware of the referral, observe the child, and discuss issues with the parents and outside providers, if appropriate. If the child is already receiving services when enrolled in the program, the staff and mental health professional, upon appropriate authorization, will work closely with the provider to follow through on suggested activities, support the parents, and report on the child's progress.

TREATMENT

Objectives

- To have access to treatment services.
- To expect information to be confidential.

Suggested Activities for Children

Head Start provides very little in the way of long-term mental health treatment services to children. If a child is assessed as needing treatment, the provider should make recommendations for classroom or home visit activities or methods of handling situations. An IEP (Individual Education Plan) would be written and teachers, home visitors, social service staff, and parent involvement staff may have assignments relating to the family or child receiving treatment. Head Start staff will coordinate services, provide support and encouragement to the child and family, follow the specific treatment plan activities, and provide all the other comprehensive services to the child and family.

Warning Signs for Children at Risk for Mental Health Problems

Extremely active
Cannot play
Fights a lot
Withdrawn
Very sad
Inadequate toilet skills
Unusual behavior

Extreme mood swings
Fearful
Inappropriate responses to situations (for example, laughs instead of cries)
Destructive to self and/or others
Very accident prone
Sudden behavior changes
Extremely immature

All of these signs must be scrutinized in terms of: intensity, extensiveness, duration, environmental events, and comparison with others. (See *SAMPLES* for other referral guidelines.)

TOUCHPOINTS

As you read the next chapters and mull over mental health in your own program, here are some things to keep in mind. Mental health is holistic, emphasizes wellness, and benefits from a prevention focus. Touchpoints to return to that guarantee you are on track include: 1) the Mental Health Performance Standards; 2) the mental health objectives and activities. Lastly, the mental health of staff and parents is as paramount to the success of Head Start as is that of the children.

PART I

SAMPLES

The *SAMPLES* provide you with additional activities which emphasize mental wellness for children and parent groups. There also are forms concerning referral which you may want to copy and/or adapt for your own use to assist in documenting mental health activities. Examples of guidelines for referring children and families to the mental health professional are also included.

IDEAS FOR MENTAL HEALTH ACTIVITIES IN THE CLASSROOM AND AT HOME
SAMPLE

1. Use mirrors. Place full-length mirrors in play areas; use mirrors to finger paint on and have hand mirrors available.

2. Take photographs. A camera is the most useful mental health tool you can have available. Try to get one donated from a local store.

3. Play name games. Use names in all different ways throughout the day. Always introduce guests by their names. Place names on all work, cubbies, placemats, rugs, toothbrushes, charts, etc.

4. Keep a book or file of children's work throughout the year. Large art portfolio folders work well. Be sure to have children select the pieces to be placed in a book at the end of the year.

5. Draw body images. Draw around body on butcher paper and discuss uniqueness. Do in small groups with time for discussion and feedback. Display and send home.

6. Display children's art at appropriate eye levels.

7. Provide quiet areas and space so children can be alone. A blanket over a card table, soft pillows, or big boxes.

8. Teach children self-reinforcement. Have them label what they do and feel. Ask children, "What do you think?"

9. Promote enjoyment of beauty and aesthetics. Children can learn to enjoy music, art, nature, and sculpture. Use art forms of all types. Libraries have resources.

10. Emphasize stress reduction. Teach children to label feelings and ways to relax. Tense and drop. Be popcorn. Do deep breaths. Soft music imagery.

Source: Hansen, K. (1988). Washington, DC: Georgetown University Head Start Mental Health Project. Unpublished material.

IDEAS FOR ACTIVITIES IN THE CLASSROOM AND HOME
SAMPLE - PAGE 2

11. Give children words for feelings. Happy, sad, joyful, disappointed, angry, grouchy. Let them know that adults have feelings, too.

12. Make lists or charts of accomplishments. "Things that made me happy today," or, "I was proud of _____ today."

13. Use books to promote discussion and make points about mental health concepts.

14. Use puppets. Puppets allow children to discuss their feelings openly.

15. Teach friendship skills. Friends are a very important part of life and skills can be learned early.

16. Use laughter and humor with children. Having a good sense of humor will take them a long way. Let children see you laugh at yourself.

17. Teach children to enjoy the outdoors and exercise. Lifelong leisure skills are important for mental health.

18. Play listening games that require children to really listen to others and respond.

19. Provide conflict resolution activities and games. Give children "pretend" situations and have them come up with ways to resolve them.

Source: Hansen, K. (1988). Washington, DC: Georgetown University Head Start Mental Health Project. Unpublished material.

PARENT GROUP ACTIVITIES
SAMPLE

Mental health services for parents are coordinated with the services provided by the parent and the social service component coordinators. Parent group objectives include:

Objective	Guidance
Increasing the parents' (caregivers') understanding of the usual development of young children.	Some parents have had little experience with young children. Because of this, they may expect their child to be able to do things before s/he is capable of doing so. Information about what most children are able to do as a toddler, as a preschooler, etc., can help parents be more realistic in their expectations of their child.
Increasing parents' understanding of their own child's development.	Parents may need additional help in recognizing their own child's current abilities and temperament. All children do not learn to do the same things at the same age. Some children develop motor skills faster, some develop language skills faster, some are able to achieve control over their behavior faster, some are able to control their strong feelings (they stop crying more easily and are less likely to have a temper tantrum no matter how upset they become). Even though most children may have a particular skill at a certain age, parents need to recognize when their child is not yet ready to achieve this skill, or needs special help in doing so.
Increasing parents' abilities to recognize and understand behaviors which are an expression of their child's response to a stressful situation.	It is helpful to parents to understand the things most young children find stressful (tension in the home due to frequent arguments between parents, loss of parents through illness/ separation/death, birth of a new sibling, starting school, etc.). It also is helpful for parents to understand that sudden changes in a child's way of behaving may be the child's response to some stress. As is the case with the teacher, helping the child to deal with the stress should be an important part of the parents' response to the child's behavior.

Source: Stone, N., Pendleton, V., & Vaill, M. (1981). *Head Start mental health manual.* (Vol. 2). Unpublished material.

PARENT GROUP ACTIVITIES
SAMPLE - PAGE 2

Objective	Guidance
Assisting parents to discuss different attitudes and approaches to parenting which can be expected to provide emotional support for their child and to help the child cope with his/her feelings and with environmental demands.	There are many differences of opinion about parenting. The one thing about which there is agreement is that there is no "right way" to parent. However, parent groups can discuss different approaches that individual parents have found helpful in their efforts to meet their child's needs and help him/her to cope with feelings and demands. Parents can be helped by talking about their own experiences and by learning from each other, as well as by materials presented in workshops or formal presentations by guest speakers.
Increasing parents' understanding of the expectations other persons, in environments such as the public schools or the community, are likely to have of their child.	This is an understanding of the "readiness" for school work and the maturity (self-help skills, ability to behave according to classroom rules, "acceptable" ways of expressing feelings, etc.) which the child must develop if he or she is to cope successfully with kindergarten and other situations after Head Start.
Increase parents' feelings of competence and self-esteem.	Parent groups in which parents share experiences and their own solutions to problems they have encountered (rather than having an expert tell them how to solve their problems) can provide support to parents as well as information about topics of interest. Group leaders should have had experience in working with groups in order to facilitate the achievement of this goal.

Source: Stone, N., Pendleton, V., & Vaill, M. (1981). *Head Start mental health manual.* (Vol. 2). Unpublished material.

CLASSROOM OBSERVATION REPORT
SAMPLE

(This form is to be used by mental health professionals when a child is being observed in the classroom, during home visits or home-based socialization.)

HEAD START AGENCY _____

CENTER _____

DATE OF OBSERVATION _____ LENGTH OF OBSERVATION _____

PURPOSE OF OBSERVATION:

RECOMMENDATIONS:

OTHER COMMENTS:

_____
Specialist's Name Date

_____
Director

Source: Hawks, D. (1978). *The mental health consultant for Head Start* (2nd ed.). College Park, MD: University of Maryland College Center for Professional Development.

MENTAL HEALTH CONSULTATION FORM
FOR OBSERVATION
SAMPLE

I, _____, grant my permission to the Arlington
Parent's Name
Community Action Program, Inc./Head Start Mental Health Consultant to observe my child, _____, in the classroom setting. A report will be
Child's Name
written by the Consultant and filed in my child's health folder. This report will be kept confidential and only myself, my child's teacher and the Health and Special Needs Coordinator will have access to said folder.

Date: _____ _____
Parent Signature

Source: Arlington Community Action Program, Inc. (1987). Arlington, VA: Head Start - Community Development. Unpublished material.

FORMA DE OBSERVACÍON PARA CONSULTA DE SALUD MENTAL

SAMPLE

Yo, _____, doy mi permiso al consultante de
nombre del padre o madre
salud mental del Arlington Community Action Program, Inc./Head Start, para que observe a mi hijo/hija _____, en su salón de clases. Un réporte escrito
nombre del niño/niña
por el consultante será puesto en el folder de Salud de mi niño/niña. El reporte será confidencial y solo yo, la maestra de mi niño/niña y la Coordinadora de Salud y necesidades especiales tendremos aceso para ver y leer el reporte.

Fecha: _____ _____
Firma del Padre o Madre

Source: Arlington Community Action Program, Inc. (1987). Arlington, VA: Head Start - Community Development. Unpublished material.

EVALUATION/TESTING REQUEST
SAMPLE

HEAD START AGENCY: _____ DATE: _____

CENTER: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

PARENT'S NAME: _____

ADDRESS: _____

NAME OF TEST(S): _____

PURPOSE OF TEST:

RESULTS OF TEST (Attach protocol; use additional sheet(s) if necessary):

RECOMMENDATIONS (Use additional sheet(s) if necessary):

_____
Specialist's Signature Date

_____
Director

Source: Hawks, D. (1978). *The mental health consultant for Head Start* (2nd ed.). College Park, MD: University of Maryland College Center for Professional Development.

MENTAL HEATH REFERRAL GUIDELINES FOR SOCIAL SERVICE/PARENT INVOLVEMENT STAFF

SAMPLE

1. Does your client seem "depressed"?

2. Are there indications of domestic violence in the home (child abuse, spouse abuse, sexual abuse)?

3. Is this family in crisis (recent death, illness, loss)?

4. Other concerns (substance abuse, recent separation, divorce)?

When it is determined that a referral is needed to the mental health coordinator or professional, here are some ways to prepare your client.

- Be aware that your client may perceive the referral as a form of rejection (they may also feel that you think they are "crazy" and that is why you are referring them).

- Help your client understand why the referral is being made ("you [client] may feel you wish to *check out* your concerns with your mental health professional").

- Help your client understand the nature of the service that the mental health professional provides (assessment of client's concerns, short-term counseling, child management, and, if necessary, referral to a community agency).

- Reassure your client that you will follow along or be available as long as he/she feels the need to contact you.

Source: Genessee County Community Action Agency. (1986). Flint, MI. Unpublished material.

MENTAL HEALTH REFERRAL GUIDELINES FOR TEACHERS
SAMPLE

1. Does the child have a greater number of problems than others his/her age?

2. Is the child's behavior generally appropriate to the circumstances which he/she is a part of?

3. Is the child's behavior generally appropriate for his/her age?

4. Are there real difficulties in the child's environment (including the classroom) that may be blamed for his/her problem?

5. Has there been a radical change in the child's behavior?

6. How severe is the problem? (Does it happen on a consistent basis?)

7. Is the child at an age that renders him/her more vulnerable to the problem? (The preschool child, for example, may be more likely than the older child to experience divorce as a personal abandonment and loss of love and blame him/herself.)

The teacher with a student who has a problem might consider three basic criteria in reaching a decision about referral.

1. Are the child's social, emotional, and intellectual needs being reasonably met within the classroom?

2. Are the rights of the other children being considered? Are you spending more time than would be appropriate on one child so that the group suffers?

3. Is your own mental health suffering and is your teaching effectiveness impaired because of this child?

Children with the following behaviors should be considered for referral to the mental health professional:

1. Withdrawn
2. Isolated
3. Secretive, noncommunicative
4. Belligerent, uncooperative
5. Physically or sexually inappropriate
6. Moody, irritable
7. No apparent organic cause for aches and pains
8. Constantly in need of reassurance
9. Frequently frightened
10. Resistant to being hugged or touched
11. Poor eye contact
12. Extremely immature

Source: (Adapted from) Genessee County Community Action Agency. (1986). Flint, MI. Unpublished material.

REFERRAL FORM
SAMPLE

(This is a form to be used by teachers to alert the mental health professional of concerns they have about a certain child.)

HEAD START AGENCY: _____ DATE: _____

CENTER: _____

CHILD REFERRED: _____ REFERRED BY: _____

PARENT/GUARDIAN: _____ TELEPHONE #: _____

CHILD'S TEACHER: _____

REASON FOR REFERRAL:

OTHER RELEVANT INFORMATION (any information that will help in understanding the child or his/her problem):

SPECIFIC SERVICES REQUIRED (Consultation with mental health specialist, classroom observation by specialist, testing, etc.):

Source: Hawks, D. (1978). *The mental health consultant for Head Start* (2nd ed.). College Park, MD: University of Maryland College Center for Professional Development.

REFERRAL TO MENTAL HEALTH PROVIDER

SAMPLE

NAME OF MENTAL HEALTH PROVIDER: _____

CHILD'S NAME: _____ AGE: _____

PARENT'S NAME: _____

ADDRESS AND/OR TELEPHONE #: _____

_____

REFERRAL SOURCE: _____

REASONS FOR REFERRAL (specific concerns, behaviors history):

What is the precipitating stressor?

What issues do you want addressed?

What specific feedback will you need?

What has the family been told about our services?

Any other information you think important?

_____

Signature and Date

Source: Tri-County Head Start Program. (1988). Durango, CO. Unpublished material.

PART I

REFERENCES

Arlington Community Action Program, Inc. (1987). Arlington, VA: Head Start - Community Development. Unpublished material.

Genessee County Community Action Agency. (1986). Flint, MI. Unpublished material.

Hansen, K. (1988). Washington, DC: Georgetown University Head Start Mental Health Project. Unpublished material.

Hawks, D. (1978). *The mental health consultant for Head Start* (2nd ed.). College Park, MD: University of Maryland College Center for Professional Development.

Seabolt, N. (1979). *Mental health services in Head Start: A guide to implementing the mental health objectives and performance standards.* Kansas City, MO: Community Development Institute.

Stone, N., Pendleton, V., & Vaill, M. (1981). *Head Start mental health manuals.* (Vols. 1 & 2). Unpublished material.

Tri-County Head Start Program. (1988). Durango, CO. Unpublished material.

PART II
MENTAL HEALTH IS EVERYBODY'S BUSINESS

The mental health component addresses complex issues which face the staff, parents, children, and ultimately the community. As you consider the challenge, it is important to be knowledgeable about your specific job responsibilities and methods you can use to complete the job effectively. Part II discusses job responsibilities, several options for staffing mental health, training, and societal problems that affect everyone.

MENTAL HEALTH COORDINATOR'S JOB

Everyone in Head Start contributes to its mental health program. Each program component has performance standards which emphasize mental health. However, in order to keep it all running smoothly, Head Start grantees need someone to coordinate the mental health component and to perform the requisite administrative duties. In your job as coordinator, you may have other components to oversee. The following information addresses the specific job responsibilities of the mental health coordinator. This information is adapted from *Mental Health Services in Head Start: A Guide to Implementing the Mental Health Objectives and Performance Standards.*

As the mental health coordinator, you have these responsibilities:

- Locate and contract a mental health professional who is knowledgeable about the type of children you serve and about low-income families. If possible, find a professional who is familiar with the cultures represented in the enrolled families.

- Monitor and coordinate the mental health professional's activities.

- Develop the mental health plan in coordination with the mental health professional, policy council, other component coordinators, and staff.

  The mental health plan sets out the program and component philosophies, the objectives for staff, parents and children, and defines activities to be completed which meet performance standards for the mental health component itself as well as for all other components as they relate to mental health.

- Track/monitor mental health activities contained in the mental health plan.

  Your job is to keep track of those mental health activities described in the plan, document them, and coordinate with other staff to make sure they are completed. A tracking system is necessary to keep clear records of such activities as training sessions, classroom and home visit observations, screening information, permission slips, and all activities planned in the area of prevention, identification and referral, and treatment. Assess your current system of tracking and redesign it as necessary to document the necessary information.

- Make certain that accurate mental health records are kept and ensure confidentiality.

  Ongoing documentation provides information and observations that are necessary in working with the child and the family. Try to have forms translated into the family's native language. This information becomes a record of progress on the child's development, helpin· parents to better understand their child's abilities, and laying the groundwork for future services after the child leaves Head Start. Because of their importance, you must assure these records are kept current and are clearly written.

  Each child's file should include the following: health records, family history, home visits by appropriate coordinators and teachers, results of screening instruments, evaluation of this data, any referral to a mental health program, a plan for follow-through, and monthly evaluations. Confidentiality must be guaranteed. (See Mental Health Professional's Job, "Individual Rights," later in this part.)

- Identify and work with available mental health resources in the community.

  The performance standards require the grantee to compile a list of community resources; mental health resources should be a vital part of that list. As you work with the social services and health coordinators to contact the agencies, look for the types of services provided, cost of services, procedures for referral, follow-through mechanisms, and a contact person within each agency. Pick the brains of your mental health professional and members of your Health Advisory Committee for additional resources. Search for resources that serve the various populations enrolled in your program (Hmong, Chinese, Vietnamese, Hispanic, etc.).

- Advocate for mental health within the Head Start program.

  This is one of your most challenging responsibilities. Mental health continues to be an easily misunderstood phrase; inadvertently people slip into thinking of it in terms of illness rather than wellness and the promotion of good mental practices. Reviving this positive concept on a day-to-day basis in meetings, planning sessions, component meetings, and staff and parent meetings is essential.

- Interact with other component coordinators on issues relating to mental health.

  Because intercomponent coordination and communication are important parts of your role, you should be aware of the performance standards in the other components which relate to mental health. As mental health filters into all components, it is up to you to initiate team meetings, working groups, and communication systems to foster the understanding of mental wellness and to promote prevention practices within all components. The job will be much easier when you are aware of the mental health activities being done by other components so you can ensure they are tracked and documented. Many good mental health activities are featured by coordinators of other components. You can also avoid a waste of valuable time and resources with regular, open communication.

MENTAL HEALTH PROFESSIONAL'S JOB

The performance standards state that *"The mental health part of the plan shall provide that a mental health professional shall be available, at least on a consultation basis, to the Head Start program and to the children."* This person can either be the mental health coordinator, if he or she is a qualified mental health professional, or someone from the community who is a qualified mental health professional interested in working with Head Start.

Performance Standards 1304.3-8 specify the responsibilities of the mental health professional (a)(1-8), the coordinator, and the Head Start staff (b)(1-8). It is the coordinator's job to arrange for all services under (a) and (b), regardless of who delivers the services. They are grouped here by level of intervention.

The responsibilities of the mental health professional, supported by the mental health coordinator, fall into the following categories:

Prevention

- Assist in planning the mental health program. *[P.S. 1304-3-8(a)(1)]*

  The yearly mental health plan is central to a successful Head Start program. Here is the opportunity to examine needs and resources with an eagle eye and to set concrete expectations for the program. By evaluating last year's activities with all those involved in Head Start -- the Health Advisory Committee, parent groups, and staff -- the professional can assist in building a realistic plan and develop a dynamic program.

- Train Head Start staff. *[P.S. 1304.3-8(a)(2)]*

  Ongoing training must be provided to meet the identified needs of children and parents in the program. Areas of training might include: normal child growth and development; observation and assessment skills; communication skills; behavioral management techniques; understanding family dynamics; identification of potential problems; information on community mental health resources. (See *SAMPLES* for *Training for Teachers and Aides*).

- Observe children periodically and consult with teachers and other staff. *[P.S. 1304.3-8(a)(3)]*

  The mental health professional must plan to observe in the classroom. It is recommended this be a minimum of two or three times a year, allowing sufficient time to confer with staff. A team meeting allows everyone to share information with the professional and gives staff opportunities to learn from the professional. This usually results in a more comprehensive plan for the child.

- Advise in the utilization of other community resources and referrals. *[P.S. 1304.3-8(a)(6)]*

  The staff looks to the professional to direct them to mental health resources available both within and outside the community in order to develop an effective, usable file.

- Orient parents and work with them to achieve the objectives of the mental health program. *[P.S. 1304.3-8(a)(7)]*

  Parents are intimately involved in the mental health of their children. Harnessing their participation by understanding their concerns, explaining mental health, and identifying and developing their skills enables them to effectively interact with children. Planning with the parent involvement coordinator can yield active parent involvement in mental health.

- Provide coordination with the education services component to provide a program keyed to individual developmental levels. *[P.S. 1304.3-8(b)(3)]*

  Constant interaction with the education coordinator helps produce an environment which benefits the children's mental health. Positive self-image, social growth, understanding a variety of cultures, and life-management skills flourish in these classrooms. If the team meeting is used as a mechanism for regular contact with the Head Start staff, appropriate assistance can be fashioned to individual children and needed training supplied.

- Assist in seeing that regular group meetings of parents and staff occur. *[P.S. 1304.3-8 (b)(5)]*

  Positive interaction between parents and staff helps to produce a strong, mentally healthy program. Work with the parent involvement coordinator to ferret out as many opportunities as possible for joint activities. They can be formal meetings such as the Parent Policy Council where they focus on the operation of the program or they can be less formal interactions such as working in the classroom or conducting home visits. These interactions provide staff with greater flexibility and parents with exposure to role modeling.

- Assure the active involvement of parents in planning and implementing the individual mental health needs of their children. *[P.S. 1304.3-8(b)(8)]*

  Parents are partners in Head Start. A program will be strengthened when parents are involved both in the overall planning within the Policy Council and in the individualized plan for their child. Once they are involved in the planning, at any level, they can become the driving forces to activate the plan.

Identification and Referral

- Advise and assist in developmental screening and assessment. *[P.S. 1304.3-8(a)(4)]*

  Screening to rapidly identify possible developmental lags and problems in children begins in the first weeks of the program. Responsibilities include working with other component coordinators to choose appropriate screening tools, training and supervising staff in the screening process or assisting in finding outside resources to conduct the screening, ensuring that the process is culturally relevant, and interpreting findings for staff and parents if more refined testing is performed.

- Take appropriate steps in conjunction with health and education services to refer children for diagnostic examination to confirm that their emotional or behavioral problems do not have a physical basis. *[P.S. 1403.3-8(a)(8)]*

  The mental health professional must work closely with the health and disabilities coordinators to ensure that the child is seen by a physician to be sure that presenting problems do not have a physical basis.

- Provide particular attention to pertinent medical and family history of each child so that mental health services can be made readily available when needed. *[P.S. 1304.3-8(b)(1)]*

  "At-risk" children need to be identified so that a plan can be created for addressing their needs. The mental health professional and the health and disabilities coordinators should both review histories of every child to pinpoint those children whose chances of experiencing problems are increased. The families' language and cultural practices must be considered. The team can then determine if more testing is needed, develop an individualized plan for the child, and assign one staff member to track progress, ensuring that recommendations are, indeed, carried out.

- Advise in the use of existing community mental health resources. *[P.S. 1304.3-8(b)(2)]*

  On occasion, Head Start personnel refer children to a community mental health resource for specific mental health services, making sure the services are also culturally and linguistically appropriate. Training staff in the referral process will aid them in providing accurate, pertinent data and in requesting specific information, thus gaining them credibility with the agency. The professional may need to act as liaison between the agency and Head Start and even advocate for the child when the process slows down or is unsatisfactory.

Treatment

- Assist in providing special help for children with atypical behavior or development, including speech. *[P.S. 1304.3-8(a)(5)]*

  Working with other component coordinators to assist the staff to plan an individualized program or to provide referral to other agencies for those children who may deviate from normal development (including the gifted child) is another aspect of this job. This includes helping staff learn skills to work with these children, acquire management techniques, and select teaching aids and games. Severe temper tantrums, extreme shyness, hyperactivity, distractibility, unusual behavior, or other difficulties are some of the problems they will need to understand in order to provide an appropriate mainstreamed setting.

- Provide opportunity for parents to obtain individual assistance. *[P.S. 1304.3-8(b)(7)]*

  Parents need to feel comfortable asking for individual help and the professional can create an environment conducive to open communication. In order to be effective, professionals must be knowledgeable of cultural attitudes and beliefs regarding mental health. By frequent interaction with parents, the professional will be able to reinforce the idea of mental wellness and solicit their concerns by demonstrating respect and empathy for them. These professionals are also responsible for making parents familiar with programs offered by community resources.

Individual Rights [These performance standards do not fall into a single level of intervention. Instead, they describe rights protected by the performance standards and they are found within all levels.]

- See that there is always parental consent for special mental health services. *[P.S. 1304.3-8(b)(6)]*

  Increasing parents' responsibility for their child and developing a deep, positive parent-child relationship are central to the program. Helping parents become advocates for their children leads them toward this goal. One such way is to keep parents involved in every facet of their child's program, including understanding and requiring their written consent as special mental health services are needed. Avoiding a blanket release and getting permission as needed is a good device for involvement. Consent includes the name of the child, the name of the service provider, purpose and description of the service to be provided, and the date the form was signed. (See Part I - *SAMPLES, Mental Health Consultation Form* in English and Spanish.)

- Assure the confidentiality of records. *[P.S. 1304.3-8(b)(4)]*

  All efforts to build a supportive Head Start program can be undone if *anyone* discovers that confidential information has been divulged about children, parents, or staff. All those who work within the program, staff and parents alike, will need assistance and constant reminders to learn to treat both records and situations in a confidential manner, especially in conversations. Keep mental health records in a locked file and create a check-out system for the few key staff with permission to use these records. Information for checking out records must require the child's name, the staff member's name, the date of checkout, and the date of return. Immediately report any breach of confidentiality to the director for resolution (Seabolt, 1979). (See *SAMPLES* for *Confidentiality Guidelines.)*

SUGGESTED PROFESSIONAL COMPETENCIES AND PERSONAL CHARACTERISTICS FOR A MENTAL HEALTH COORDINATOR AND THE MENTAL HEALTH PROFESSIONAL

Both of these jobs require experience with young children and families. They also often have overlapping competencies.

PROFESSIONAL COMPETENCIES

Coordinator

- Understands the referral process
- Comprehends the basic principals of resource development and utilization of consultants
- Coordinates comprehensive health services delivery according to prioritized needs
- Demonstrates recognition and support for parental involvement in all aspects of the delivery of child health services
- Facilitates team building
- Understands family history and assessment protocols
- Works to assure that the available child health delivery systems are flexible, accessible, and responsive to family needs

Professional

- Professional qualifications*
- Knowledge of alternatives in treatment including behavior management
- Knowledge of family systems
- Ability to work with families in the referral process
- Ability to recognize and reconcile differences in style and behavior of staff

Both

- Observation skills
- Communications skills: verbal and written
- Organizational skills: recordkeeping, coordination, follow-up
- Ability to integrate mental health activities and philosophies with functions of other components
- Understands low-income families, cultural differences, and group dynamics
- Ability to effectively implement changes in the program

* The standards themselves do not designate the qualifications of mental health professionals. However, the guidance, which is meant only to give suggestions of good practice, suggests "A mental health professional is a child psychiatrist, a licensed psychologist, or a psychiatric nurse or psychiatric social worker. Both the psychiatric nurse and psychiatric social worker should have experience working with young children."

51

The qualifications of the mental health professional is an area which raises many questions and concerns for programs. Some regional Administration for Children, Youth and Families (ACYF) offices have distributed guidelines of their own recommending what qualifications programs should seek in a mental health professional. Check with your regional office to see if such recommendations exist.

Working in a Head Start program is rewarding, but it can also be frustrating and stressful. Certain personal attributes ease the jobs of both the mental health coordinator and the mental health professional.

PERSONAL CHARACTERISTICS

It's vital to

BE:	nonjudgmental	HAVE:	a sense of humor
	sensitive		personal maturity
	creative		high self-esteem
	caring		the ability to tolerate stress
	empathic		an appreciation for differences
	optimistic		the ability to work with colleagues

ENJOY: working with children and families

ALTERNATIVES TO STAFFING THE MENTAL HEALTH PROGRAM

While all the responsibilities of the mental health coordinator and the professional must be carried out, they can be distributed in different ways to best suit your program's needs. The distribution depends on a variety of factors: availability of local mental health resources, funding, demographics, configuration of the Head Start program (center-based, home-based). The following are ways other programs have staffed their mental health component. In each case they clearly define the roles and responsibilities.

PROGRAMS USING MENTAL HEALTH CONSULTANTS

Often programs are limited in the number of mental health professionals available locally or in the amount of money allocated for mental health. Sometimes a Head Start director may decide that hiring a mental health professional as a full-time staff member is not the best use of funds, but that contracting a variety of professionals to address specialized programs is preferable.

Consultant as Sole Mental Health Professional

Grantees frequently use a staffing pattern in which the mental health coordinator is an employee of the Head Start program and has primary responsibility for coordinating and monitoring the delivery of services and a mental health professional is hired from the community to provide direct services to staff, parents, and children. This contracted person may lead parent meetings, providing individual counseling and intervention in crises. The mental health professional works closely with the coordinator to oversee the total program and ensure that activities in prevention, identification and referral, and treatment are taking place.

Where necessary, the mental health coordinator may hold another position in the agency, often as the coordinator of health, social services, or education. In such instances, it is advisable that the coordinator be in either the components of Health or Social Services since training in these fields will most likely have included information on mental health and the nature and availability of community resources. He or she may not have strong training in the area of mental health and will rely on the mental health professional for guidance and assistance.

Staff Professional With Consultant as Supervisor

Other grantees facing financial constraints or limited availability of qualified mental health professionals use a different tack. They employ a person who has mental health training and credentials, but who does not have the qualifications required by the state to perform assessment and diagnosis. This person usually has sufficient expertise to advise and do screening, observe in the classroom or on a home visit, design and run parent or staff support groups, train staff and parents on positive mental health practices, and advocate effectively within the program and community for mental health services.

This alternative *requires that the staff person be under the supervision of a licensed mental health professional* who has the qualifications which meet state requirements. The professional who supervises this person may be from a community mental health center, another community agency, a university, or may be a private provider.

Consultant as Trainer and Resource

This model originates from the premise that all staff will face mental health challenges in the day-to-day interaction with other staff, children, and parents. These grantees provide training to *all* staff members in basic mental health skills including interviewing techniques, observation techniques, crisis and intervention skills, some intervention practices, and warning signs of at-risk behaviors. In this model, an outside consultant who meets state requirements handles assessments and referrals. After receiving referrals from the staff, the consultant decides with them and the family if intervention is needed. For example, the classroom staff is trained to conduct classroom observation and asks the consultant to come in if a problem is suspected. Otherwise, the consultant may not have to do more than one classroom observation per year.

53

PROGRAMS WITH STAFF MENTAL HEALTH PROFESSIONAL

Some programs have a mental health professional who is qualified by the state to do assessment and diagnosis, is on the Head Start staff, and provides direct services within the Head Start program. These services include providing ongoing support to staff and parents, overseeing screening, performing classroom observations, working with parents, leading or supervising other training sessions, conducting diagnostic work-ups, or referring children and families to outside agencies for treatment.

There may also be a mental health coordinator in this model. In that case, the duties would be divided and the structure would look very much like the consultant models only the mental health professional would be a Head Start staff member.

PROGRAMS WITH MENTAL HEALTH AIDES

Multicultural

The following approach exemplifies how all components interrelate when dealing with Head Start families who are foreign born. This approach was developed through an innovative Head Start grant and was named Project Bridge. Much of the following information is adapted from the manual, *Project Bridge: A Cross-Cultural Approach to Mental Health in Head Start.*

Many Head Start grantees are facing the increasing challenge of enrolling more foreign-born and non-English speaking children. While some programs have families from only one language group, some centers have as many as fifteen or more separate languages spoken by families. In all cases, Head Start staff need assistance in learning the culture, comprehending communication styles, understanding the social and emotional needs of the children and families, and assisting families to become integrated into American society while keeping the richness of their own heritage.

Families who have recently arrived in this country may have more mental health needs than those who have lived here for a long time. Leaving one's country, either by choice or by force, places great stress on the family. Language barriers, lack of work, lack of appropriate clothing, loss of a close-knit family support structure, and lack of knowledge of child-rearing expectations in this country increase the demands on parents' mental health reserves.

Some Head Start grantees that face this challenge have designed a mental health program to support these families and assist Head Start staff in understanding the culture and values of the families' country of origin. In this design, a mental health professional, either the consultant or mental health professional on staff, oversees the majority of the

program. In addition, mental health aides are hired or contracted to assist with the foreign-born families. These aides are people from the culture who understand and speak the language. Ideally, they have some sort of mental health or social service background, but that is usually not possible. They receive training on Head Start, community resources, crisis intervention, normal child development as seen from the American perspective, appropriate child management techniques, and basic mental health information.

These mental health aides may assist families to: obtain appropriate resources, complete needed Head Start forms, become involved in the program, meet others from similar cultures, understand normal child growth and development, understand the American culture and expectations, and discuss their concerns and problems. They may also help the Head Start program staff to understand and respect the various cultures by translating, answering questions, and serving as a liaison within the community. Often they work with children, fill out forms, and inform staff of community services.

These aides are under the supervision of the mental health professional and do not provide therapy or treatment services (unless they are qualified mental health professionals), but are active in prevention services and serve as a translator if a need for intervention services arises (Cook, 1987). For information on the definition and guiding principles of a culturally competent agency, see *SAMPLES* for *What is a Culturally Competent Agency?*

Extensive Geographic Area

Programs that serve a very large geographic area may have difficulty finding mental health resources. The mental health aide model is often used in these programs. The roles, responsibilities, and training of aides would be similar to those listed above. In some cases, teachers and/or home visitors are trained by a mental health professional to be observant of behaviors which may be an indication of mental health concerns. The mental health professional supervises the aides and elicits their concerns and suggestions on a regular basis. This can be done through meetings, phone calls, conference calls, or satellite hook-ups. If it is decided that intervention is needed, the mental health professional proceeds with the process of further observation, discussion with the parent or staff member, and referral, as appropriate.

In many rural areas it may be difficult to find a mental health professional. It takes creativity and persistence. Many programs have found people by advertising in the local community papers, working with the health departments and public schools, and coordinating and trading services with other agencies serving the area. (For more ideas see: Ways and Means to Staff Mental Health, "So You've Decided What You Want, Where Do You Find What You Need?") The mental health aide model allows trained Head Start staff to do the preliminary observations and lead some mental health prevention and education activities with the families, and brings in the professional at times when their expertise is needed.

HOME-BASED PROGRAM OPTION

Head Start allows a number of choices in serving families. The home-based program option emphasizes the role of the parent as the primary educator of the child. A Head Start home visitor regularly works with the child and family in the home setting. Through a series of planned activities, the home visitor assists the family to build on its strengths and address developmental and educational issues.

In some home-based program options, the home visitors receive intensive training in several areas of mental health. Because they see the parents each week, it is important for them to know risk indicators of possible mental health problems, community resources, the basics of crisis intervention techniques, and interviewing and listening skills.

The home visitor is not expected to be a mental health professional or provide therapy services. These programs have a mental health professional available who is given referrals and concerns. Because they go into the homes once a week, home visitors often develop the most significant relationship with the parents and hear or see things which may concern them or which they have to deal with on the spot. Therefore, extra mental health training is of importance for programs that choose the home-based program option.

SHORT-TERM PROGRAMS

Short-term Head Start programs such as migrant programs face all of the requirements previously mentioned and must carry out the mental health component in an intense fashion. Before the program starts, the coordinator and the professional must:

- Learn about community resources and contact them to inform them of Head Start goals and objectives.
- Decide on screening procedures, a brief process so services can be obtained in a short amount of time.
- Devise a tracking and documentation system so records can follow the families.
- Learn of the general needs of the population served.
- Train teachers and other staff on general mental health principles including useful prevention activities.
- Train staff on referral procedures.

As with any other program, the mental health services provided in these programs must meet the performance standards. The key to achieving that goal is to establish a plan of action well ahead of time, hire extra mental health staff, if possible, establish a good working relationship with community resources so they understand the needs of the population, acquire written resources in the appropriate language with suitable reading levels, and be ready to go when the program opens.

WAYS AND MEANS TO STAFF MENTAL HEALTH

HOW DO YOU DECIDE STAFFING?

The roles of the mental health coordinator and the mental health professional are vital to your program. Managed well, they will strengthen all the other components of Head Start and deepen the satisfaction of all. People working in a mentally healthy environment like to come to work.

Take Stock -- Before deciding the staff model you are going to adopt, take into consideration these elements:

- Result of the agency and parent needs assessment
- Availability of community resources
- Financial constraints of your agency
- Philosophy of the agency on mental health
- Evaluation of present staffing patterns

Count Up Your Money -- The mental health budget is generally, but not always, part of the greater health budget. Responsibility for its development and management on the part of the mental health coordinator varies from program to program. It is important that you have a clear understanding of your responsibility for the mental health budget with your director. Regardless of your role in decision making or management, it is essential that you know how much money has been allocated for mental health activities. It may be helpful to provide fiscal information to your director about staff salaries, consultant fees, equipment, material, supplies for center-based and home-based program options, staff development, travel, tracking, monitoring, and evaluation.

Most of the mental health budget will be allocated to staff salaries and mental health consultant fees. The staff model you select has an enormous effect on the budget. Review staffing alternatives and determine if you could make your budget go further with some creative staffing and budgeting.

Money Hints:

- Pool your mental health dollars with another nearby Head Start grantee to buy more of a professional's time. This lends itself to a greater presence of the mental health professional in each program.

- Add your training dollars for mental health related topics to money from other nearby agencies. This is not only cost effective, but it also builds collegial support networks and allows for the sharing of expertise.

57

- Investigate use of psychology and psychiatry trainees, and social work graduate students as one-year interns on your staff. Most universities and colleges are looking for appropriate field placements for their students. Supervision could be arranged with a local professional if one is not on staff or supervision could be conducted through the student's own university staff. At no cost or very minimal cost, this could provide you with a staff person for three days a week, if not full time.

As the mental health coordinator, begin to build a strong list of justifications for more professional mental health services. Indicate how these services benefit the other components (see Appendix B Mental Health Related Performance Standards.)

In many areas it is not a question of what the qualifications, skills, knowledge, or personal characteristics of the person are, but whether there is anyone at all available to be a mental health consultant. Sometimes you have to use your creativity and community connections, or restructure your staffing depending on the people available in your area. Take a look at the staffing alternatives mentioned earlier in this chapter.

SO, YOU'VE DECIDED WHAT YOU WANT, WHERE DO YOU FIND WHAT YOU NEED?

Places to begin looking for a mental health professional include: (This information is adapted from *Integrating Mental Health into Head Start).*

- Other Head Start programs. Ask a neighboring Head Start director or mental health coordinator for suggestions and recommendations.

- Community mental health centers. For a complete list, contact the state chapter of the National Association of Community Mental Health Centers.

- State departments (health, mental health, maternal and child health, education, and special education). They may have a list of people who have the qualifications you are seeking.

- University departments of psychology, psychiatry (child psychiatry program), social work, early childhood education, and pediatric medicine.

- County health departments and clinics (child welfare, public health, court systems).

- Local schools.

- Private providers: Look in the telephone book for local and state chapters of professional organizations such as the National Association of Social Workers. They maintain a membership list of qualified professionals.

- Family service agencies: These are usually listed in the telephone book under social services or mental health services.

- Guidance centers: These are usually listed in the telephone book under social service or mental health services.

- Hospital departments of social work, psychiatry, child psychology, and pediatrics.

- State and local mental health associations and professional organizations.

- PHS Regional Mental Health Coordinators/Consultants.

If you need hints on how to approach these agencies, see *SAMPLES* at the end of this part.

Once an individual or an agency is interested in providing services to Head Start, the negotiations begin on such matters as tasks, timelines, and payment policies. Negotiations give both parties a chance to reflect on and select the responsibilities they will have when a written agreement is developed. Administrative issues should be firmly established for both parties. You should discuss and negotiate payment services, the designated liaison person between the provider and Head Start, means of referral, as well as other specific issues. These discussions should then be formalized into an agreement.

The contract is a legal, binding agreement between your program and the provider. Be sure that it includes, in specific terms, what services you have contracted for, when they will be provided, termination rights, and methods of payment. The *SAMPLE* section at the end of this part contains an agreement, a contract, a memorandum of understanding, and a summary sheet to track consultants' time/services. These samples can be adapted and changed to fit individual program needs. For example, a home-based option will want to include in the contract observations in the home or during socialization sessions.

If you carefully document your decision-making process, achieve the goals of the performance standards, and meet the objectives and goals you have set for your agency, you will be able to explain your choice of a mental health professional (Riley, 1984).

TRAINING THAT WILL HELP

No matter how the responsibilities for mental health are distributed, orientation and training are essential to acquaint staff members with their responsibilities in the mental health area. It is also important to give parents information on the program goals of mental health and an understanding of a wellness approach. (See Part I - *SAMPLES* for *Parent Group Activities* and Part II - *SAMPLES* for *Handout for Orientation Meeting*, and *Training for Teachers and Aides.*)

STAFF AND PARENTS: One of the best, and often neglected, methods of ensuring that all staff and parents are aware of the program's mental health philosophy and its relevance to their jobs is to present an orientation training session at the pre-service in the beginning of the year. The coordinator would work with the mental health professional to develop this presentation.

Training on mental health related areas should not stop at pre-service. Training should be scheduled throughout the year to reinforce the concepts and principles presented at pre-service, teach new skills, and offer staff and parents the opportunity to discuss their feelings and thoughts in this area.

MENTAL HEALTH COORDINATORS: The mental health coordinator, working closely with professionals who are not members of the Head Start staff, provides some mental health services which differ from that of other component coordinators. Additional training is recommended for the staff member who takes this position in order to provide him or her with the required skills. (See *SAMPLES* for *Training for Mental Health Coordinator.*)

THE MENTAL HEALTH PROFESSIONAL: Once a mental health professional is hired or contracted with, it is important to thoroughly orient him or her to the Head Start program. Since mental health touches all areas of Head Start, the orientation will be most effective if it is done in conjunction with all component coordinators and key administrative staff. This will ensure that the professional begins duties with an understanding of the job and how it relates to the total program. (See *SAMPLES* for *Training for Mental Health Professional.*)

All the information a mental health professiona' needs cannot be assimilated in one orientation session. To ensure communication and continuity within the program, set up times throughout the year to meet with the professional, other coordinators, teachers, and the director to discuss and brainstorm the mental health program.

COMPONENT COORDINATION

The overall responsibility for the mental health effort in your program is yours as well as the component coordinator's.

RESPONSIBILITY is a very interesting word. It is a combination of the words RESPONSE and ABILITY. "Response" means to answer or reply. "Ability" means power, ingenuity, talent, attitude, expertness, strength, ableness, and capableness.

Part of your response -- reply -- to your roles and duties as the mental health coordinator is to be aware of others' strengths and their abilities -- capableness -- in the areas of mental health.

You are not alone in the implementation of your agency's preventive mental health philosophy. The Head Start Performance Standards, objectives, and comprehensive approach imply that mental health is the responsibility of administration, staff, parents, and children. Everyone is in this effort together. All are encouraged to reply to the needs of one another and to use their individual talents and power to promote the agreed-upon program philosophy and to meet the goals of the mental health program.

The comprehensive model of Head Start was designed so all the components would work together to promote a wellness approach to program services. However, as the program grew and the demands of each component increased, roles and responsibilities sometimes became pigeonholed and "turfism" began to interfere with the ability of the components to work together as closely as originally envisioned. Mental health, being clearly a part of every component's responsibilities, is a logical place to encourage and practice inter-component coordination.

For example, if a new curriculum is introduced, it may be seen as the education coordinator's domain to evaluate it and provide training to the teachers. Curriculum selection and development, however, is a perfect place for the education coordinator, mental health coordinator, and/or mental health professional to combine their talents to meet many of the Head Start Performance Standards. An ideal area for coordination is Performance Standard 1304.2-2 which states, "Provides an environment of acceptance which helps each child build ethnic pride, develop self-concept, enhance his individual strengths, and develop facility in social relationships." The mental health coordinator and professional can evaluate the material through their "mental health eyes," looking for the elements which promote good prevention practices while the education component coordinator looks for the developmental appropriateness of the activities as well as cultural appropriateness. The disabilities coordinator should also look at the curriculum to express ideas on how well children with disabilities could function within the curriculum structure. The parent involvement coordinator needs to be informed about the curriculum structure and philosophy so she or he can respond intelligently when parents ask questions.

All components must coordinate their efforts to ensure a smooth and confidential identification and referral process. Often, the mental health professional comes to the program to do an observation of a child, yet is not able to meet with the teaching staff ahead of time to discuss their observations of a child or talk to the teachers after the session to relate the findings. The teacher may discover later that the family has been referred for assistance without the teacher's knowledge. The mental health professional could have received valuable information from the teachers if there had been a scheduled time to discuss the findings and if the teachers had been trained in appropriate observation techniques. As the mental health coordinator, it is important that you work with all the other coordinators to plan procedures and policies that include all other components and individuals who can add valuable information to a specific situation.

Staff and parent training is another place that component coordination and planning have impact. All components emphasize training. For example, parent training on child growth and development is required. The parent involvement coordinator can work with the

mental health coordinator and/or professional to be sure that the trainer covers social and emotional needs and also addresses places to seek assistance in the community.

The social services plan requires that emergency assistance or crisis intervention be provided (P.S. 1304.4-2). The social services coordinator and the mental health coordinator can plan together to make sure that staff are trained in culturally appropriate, realistic crisis intervention techniques and that referral procedures are understood and in place. Working together will ensure that resources are used effectively and the training of the staff is clear and consistent with the Head Start philosophy and procedures.

The social services component is also required to provide families with information about community resources. Coordinators can work together to identify resources in the community that provide appropriate services, including mental health. For example, services may need to be located for families who do not speak English. The coordinators would work together to find a local community college which offers ESL (English as a Second Language) classes, discuss the concern with the policy council, or find a counselor who speaks the language to provide a support group to the families.

The mental health coordinator can also contribute to the program by working closely with the administrative staff. For example, if staff morale is low, or there is a large amount of conflict among the staff, the mental health coordinator and/or professional can work with the director to plan training sessions, support groups, or other activities to help alleviate the problem.

Head Start plays a key role in the community. Because Head Start is comprehensive, it reaches into all areas of the community: from the churches where space is rented, to the social service agencies utilized by the families, to the schools where services are obtained for children with disabilities, to the grocery stores where food is bought and the children go for field trips. Head Start has an impact on each community it serves; the needs and atmosphere of the community also affect the Head Start program. How Head Start staff react to a community situation often reflects the mental health philosophy of the program.

An example is described below of how Head Start staff from all the component areas work together with resources in the community to resolve a situation which is potentially destructive to the mental health of the community.

Small towns often lack professional services and resources and have to rely heavily on good relations with the community for support to run a Head Start program. In one such community, the Head Start program had three classrooms in a church on Main Street in a predominantly white neighborhood. Several black families lived in the apartment house behind the church and sent their children to the program. The staff made a special effort to reach out and make these families comfortable. Over the course of a year, some of the parents became less intimidated by their surroundings and started to come regularly to parent support sessions and to

volunteer in the classroom. Through the program, they got to know a lot of the other parents in the neighborhood, and their children began to make good friends with some of the other Head Start children.

When some kids broke into the church looking for money to support their drug habit and found none, they savagely vandalized the building. Rumors began circulating that a couple of the vandals were from the apartment building even though similar incidents had occurred involving a gang of kids from another part of town. The church elders temporarily closed down the building and notified the Head Start director they were considering asking the program to find classroom space elsewhere.

In a program in which the roles of staff, parents, and children are tightly interwoven, the impact of such a crisis is felt by all.

Staff...

Felt anxious and upset.

Faced growing anger of the community towards the black population and Head Start.

Had to act professionally and with great confidentiality when talking to families about the situation.

Received many questions about drugs.

Parents...

Were uncomfortable dealing with the families from the apartments, although many understood the pressures these families were facing.

Had to respond to their children's questions and their neighbors' implied accusations.

Began to seek out members of the church to express sympathy and persuade them to keep the program.

Children...

Became anxious and wanted to go to school.

Didn't understand why people were saying "yucky" things about their friends.

Drove their parents wild with their tense behavior.

The Mental Health Coordinator...

Felt torn in a dozen directions.

Had to get mental health resources to provide techniques for staff, parents, and children in conflict resolution, in how to handle racial tension, and in stress management.

Designed activities for parents and children to bolster self-esteem.

63

To remedy the problem in the example above, the Head Start director worked along with his staff to implement the following plan of action. This incorporates all components of the Head Start program and demonstrates how the components are woven together.

ACTION PLAN	HEAD START COMPONENTS
Talk with the mayor, pastor, and other community leaders to plan ways to diffuse the anger and shock.	• Administration • Mental Health
Meet with parents to decide on a plan to reestablish center.	• Parent Involvement
Plan community-wide drug information seminars using schools, police, and other agencies.	• Social Services
Arrange for Head Start parents to assist in fixing the church.	• Parent Involvement
Bring in mental health professionals from the community or outside to work with families and community to dispel growing racial anger.	• Mental Health • Social Services • Parent Involvement
Use mental health professional to provide individual and support group sessions for staff.	• Mental Health
Have Head Start staff trained by professional on intervention techniques and/or reactions to look for in children.	• Education • Mental Health
Coordinate fund raiser to replace supplies and materials lost.	• Administration with the help of all components
Develop program for children to discuss the changes.	• Education • Mental Health

The Head Start program is in a powerful position to begin restoring mental health through its holistic, comprehensive approach.

The situation was dealt with effectively because, as mentioned before, it is everybody's "response" and "ability" to work together in a situation that makes Head Start the perfect place for encouraging and re-establishing mental health. The various component coordinators working with the mental health coordinator, professional, and the staff, parents, children, and community have the ability to forge a strong response to any situation.

Prevention activities, as well as identification/referral and some treatment activities, are included in the performance standards for the other components. Those standards which are outside the mental health component are primarily the responsibility of that component coordinator. However, as mental health coordinator and overseer of mental health in the program, you do have some responsibilities to other component coordinators to:

- Be aware of all performance standards, in all components, which relate directly to mental health. (See Appendix B.)

- Work with each component coordinator to help implement these standards and offer available resources.

- Ensure that documentation is kept of all activities and events relating to mental health.

Given this brief look at examples of mental health performance standards at work within other components, it is very clear that mental health is truly everyone's job in Head Start. The task of coordinator becomes one of assisting staff and parents to recognize that they are already engaged in mental health activities every time they interact with another human being. Through their interaction and activities, they either contribute to a preventive mental health approach or to the never ending list of problems that we each face in daily living.

PROBLEMS OF THE DAY: INDICATORS

Many glaring issues face Head Start staff, parents, and communities. There is always a need for colleagues and parents to have skills in recognizing the symptoms of various problems related to mental health and in knowing the referral process. Many staff and parents are experiencing similar problems in daily living: poverty, poor self-esteem, alcohol and other drug abuse, domestic violence, chronic illness, depression, poor problem-solving skills, inadequate living conditions, violence in the community, isolation, and poor interpersonal communication skills, among others. Generally you become aware that a staff member or parent is having difficulty if you notice a drastic change in the persons's "usual" behavior -- an inability to concentrate, unreliability, or decline in performance (stops going to work or is no longer available for home visits).

These problems may stem from a lack of self-esteem. There is often a strong correlation between substance abuse and low self-esteem. People who have not learned good mental health practices, such as problem-solving, coping skills, and the ability to ask for help, may turn to alcohol or other drugs. If this happens, they may become involved in a vicious downward cycle of destruction, causing serious problems for themselves, their families, and their children. Head Start programs across the country are facing this challenge daily and must provide a strong prevention program as well as be able to locate resources for staff and parents who are already in the cycle.

As mental health coordinator, it is your responsibility with the assistance of the mental health professional, to make your staff aware of the signs and symptoms of some of the problems common to the community. These problems are bigger than the Head Start program and have an impact on the whole community. To assist you with making plans for your program, it is important to find out what resources are available and how the community leaders are working together to solve problems. Belonging to community organizations and task forces is one way to become aware of actions being taken in your community. It is your job to know the problems and resources in the community so you can provide assistance both to the adults working in the program and to the children and families you serve.

Included in the *SAMPLES* section following this chapter are information sheets on some of the prevalent problems currently facing Head Start programs. There are sheets on substance abuse, the depressed child, depression in adults, child sexual abuse, and self-esteem. These sheets are designed to give you only a brief overview of the problem with basic information on what you might see in a person who is having such a problem. Your mental health professional and local community and state organizations can provide in-depth information and assistance if you need it. Also be sure that everyone in the program knows the referral and reporting process so the confidentiality of individuals is protected.

As mental health coordinator, you must also take care of yourself. Remember, you will be viewed as a model of preventive mental health strategies in action. Review the mental health principles. How are you implementing each of them in your daily interactions? What are you doing for your own self-esteem -- going for a long walk, taking a luxurious soak in the tub, exercising, watching your nutrition, spending time with friends and family, or other forms of self-help/self-care that come to mind. Take good care of your own mental health.

In summary, the interrelatedness of mental health objectives and standards throughout Head Start is your program's foundation. If this foundation is weak, the entire program will be weak. If it is strong, all participants will benefit.

You are not alone. You have the support of all other components in meeting the objectives of the mental health program.

The next part of the manual details a step-by-step planning process which allows you to build on this foundation. This, too, is a collaborative effort.

PART II

SAMPLES

The SAMPLES provide information and ideas on how to improve your agency's approach to cultural differences. They are also examples of contracts and agreements with individuals and agencies that provide mental health services. These samples can be copied and/or adapted for your specific needs.

Ideas for training topics and several handouts on mental health issues also may help to provide information to staff and parents on a variety of mental health issues.

WHAT IS A CULTURALLY COMPETENT AGENCY?
SAMPLE

Culturally competent agencies are characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of minority populations. Such agencies view minority groups as distinctly different from one another and as having numerous subgroups, each with important cultural characteristics. Culturally competent agencies work to hire unbiased employees, seek advice and consultation from the minority community, and actively decide what they are and are not capable of providing to minority clients. Culturally competent agencies seek minority staff whose self-analysis of their role has left them committed to their community and capable of negotiating a bicultural world. These agencies provide support for staff to become comfortable working in cross-cultural situations. Further, culturally competent agencies understand the interplay between policy and practice, and are committed to policies that enhance services to diverse clientele.

Guiding Principles

1. The family, as defined by each culture, is the primary system of support and preferred point of intervention;

2. The system must recognize that minority populations have to be at least bicultural and that this status creates a unique set of mental health issues to which the system must be equipped to respond;

3. Individuals and families make different choices based on cultural forces that must be considered if services are to be helpful;

4. Practice is driven in the system of care by culturally-preferred choices, not by culturally-blind or culturally-free interventions;

5. Inherent in cross-cultural interactions are dynamics that must be acknowledged, adjusted to, and accepted;

6. The system must sanction and in some cases mandate the incorporation of cultural knowledge into practice and policy making;

7. Cultural competence involves determining a client's cultural location in order to apply the helping principle of starting where the client is and includes understanding the client's level of acculturation/assimilation;

Source : Cross, T.L., Bazron, B.J., Dennis, K.W., & Isaacs, M.R. (1989). *Towards a culturally competent system of care. A monograph on effective services for minority children who are severely emotionally disturbed.* Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

WHAT IS A CULTURALLY COMPETENT AGENCY?
SAMPLE - PAGE 2

8. Cultural competence involves understanding cultural preference in order to support client self-determination;

9. Cultural competence functions with the recognition that, in order to provide individualized services, clients must be viewed within the context of their cultural group and their experience of being part of that group;

10. Cultural competence functions with the acceptance of a client's culture as it really is, without judgment, and adapts service delivery to fit the context within which the client functions;

11. Cultural competence involves working in conjunction with natural, informal support, and helping networks within the minority community, e.g., neighborhoods, churches, spiritual leaders, healers, etc.;

12. Cultural competence extends the concept of self-determination to the community. Only when a community recognizes and owns a problem does it take responsibility for creating solutions that fit the context of the culture;

13. Culturally competent services seek to match the needs and help-seeking behavior of the client population;

14. Culturally competent services are supported and enhanced when the system of care functions as an integrated support network;

15. Community control of service delivery through minority participation on boards of directors, administrative teams, and program planning and evaluation committees is essential to the development of effective services;

16. An agency staffing pattern that reflects the makeup of the potential client population adjusted for the degree of community need helps ensure the delivery of effective services; and

17. Culturally competent services incorporate the concept of equal and nondiscriminatory services, but go beyond that to include the concept of responsive services matched to the client population.

Source : Cross, T.L., Bazron, B.J., Dennis, K.W., & Isaacs, M.R. (1989). *Towards a culturally competent system of care. A monograph on effective services for minority children who are severely emotionally disturbed.* Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

HEAD START CONTRACT
SAMPLE

CONTRACT

School Year _____

Now on this 1st day of September 1989, this agreement is entered into between the County Health Department, hereinafter referred to as the Health Department, a part of the District XI Guidance Clinics, which is a division of the Oklahoma State Department of Health, by virtue of the authority vested in it by Title 63, O.S. 1981, Section 1-2016, and the Head Start, in County, by virtue of the authority vested in it by _____.

The purpose of this contract is to provide Speech, Language, Development, and Psychological services by the aforementioned County Health Department Guidance Services to the Head Start programs.

I. SERVICES AND TERMS

A. Evaluation and Assessment

1. Speech, Language, and Hearing

a) Speech, language and hearing consultation and screening will be provided by a master's level speech/language pathologist employed by the Health Department.

b) Speech and language diagnostic evaluations will be provided where indicated.

c) The speech/language pathologist will interpret the findings with the parent/legal guardian and staff the results with Head Start personnel.

d) In the event that speech therapy is needed, the speech pathologist will assist in writing the individual education plan for the child.

2. Psychological and Developmental Evaluations

a) Psychological Diagnostic Evaluations will focus on questions concerning a child's intellect, development, behavior and emotions.

b) A psychological evaluation may include an intake interview with the parent/legal guardian, observation of the child at the Head Start Center, intellectual assessment, developmental assessment and behavioral/emotional assessment.

c) The psychologist will interpret the evaluation results to the parent/legal guardian and Head Start personnel.

d) In the event psychotherapy and/or psychological evaluation is recommended for a specific child, the psychologist will assist in writing the individual education plan for the child.

Source : Davis, W. (1988). Oklahoma Department of Health. Unpublished material.

CONTRACT
SAMPLE - PAGE 2

B. Treatment Services

1. Speech and Language treatment services will be provided where indicated to children individually or in small groups.

2. Psychological treatment may be provided to children individually, to families, and/or to children in small groups.

C. Mental Health and Parent Enrichment Services

1. On-site observations of Head Start classrooms and children will be conducted by a Health Department Guidance Service clinician, i.e., psychologist, child development specialist. Head Start director or classroom teacher will be contacted in advance to schedule the observations. During the on-site observation, the Guidance Clinic clinician's duties may include:

   a) Observations of classroom procedures, management, atmosphere, physical layout, and teacher/student health.

   b) Observations of children who may be possible referrals for individual evaluations. The observation of the children by the clinician will actively involve the classroom teacher's impression, knowledge and observation of the children.

   During the verbal feedback session, the clinician will review the observations and make recommendations to the classroom teacher. Permission from the children's parents/legal guardian is required for the Health Department Guidance Service clinicians to selectively observe a child. The Head Start staff are responsible for obtaining written permission from the parents.

2. Consultative Services

   a) The Health Department Guidance Services' clinicians will be available to advise Head Start staff about the local and nonlocal resources for services, and to assist Head Start staff in arranging for diagnostic or physical examinations for students with physical, emotional, or behavioral problems. The Health Department Guidance Services will be available to advise Head Start staff to assist in planning of mental health activities for their classrooms and relevant mental health issues.

3. In-Service Training Workshops and Group Meetings

   a) Health Department Guidance Services' staff will be available for Pre-Service Workshops, In-Service Workshops, staff meetings, Parent Group Meetings. Head Start staff will be responsible for the recruitment and attendance of the parent/legal guardian.

   b) All In-Service Training will be provided by Health Department Guidance Service psychologist, social workers, child development specialist, and speech/language pathologist with approval of Clinic Directors or the District Coordinator.

Source : Davis, W. (1988). Oklahoma Department of Health. Unpublished material.

4. Screening Services

   a) All children will be provided developmental, intellectual, physical (fine and gross motor coordination), behavioral, emotional, speech, and language screenings.

D. Service Location

1. Most evaluation and treatment services will take place at the Health Department Guidance Clinic. Consultation, observation, screening, In-Service Training, and Parent Groups may take place at the Head Start facilities, or other location, if both parties are in agreement.

   Special management to provide evaluation and/or treatment services at the Head Start facility may be made if the facility is quiet, comfortable, and can provide for a confidential setting.

E. Written Interpretation and/or Feedback

1. Following assessments and evaluations, written interpretation and/or feedback will be provided to the parents/legal guardians. A report will be provided to the consortium Special Needs Coordinator by the Health Department Guidance staff within two weeks.

F. Report and Case Files

1. A copy of the evaluation and report will be kept in a Health Department Guidance Clinic locked file and one copy of the report will be sent to the Special Needs Coordinator or Head Start Director for maintenance in their locked files. All reports should contain a statement of the handicapping condition according to Head Start Transmittal Letter 75.11. If no handicapping condition exists, a statement should be made that no handicapping condition exists as referenced in TL 75.11.

G. Referral Procedure

1. Referral of students to the Health Department Guidance Clinic for services will be the responsibility of the consortium Special Needs Coordinator and/or Head Start Director following the team screening.

2. Guidance staff will provide screening services for all children in Head Start. Guidance staff will also provide consultation services to the Head Start program.

3. A Health Department Guidance Clinic Child Application and release of information forms will be sent either directly to the parent or to Head Start, depending on which is most appropriate.

4. Upon return of the Health Department Guidance Clinic forms, an initial session will be scheduled with the parent and child as soon as possible to commence the service.

Source : Davis, W. (1988). Oklahoma Department of Health. Unpublished material.

CONTRACT
SAMPLE - PAGE 4

5. Treatment services will be provided after the notification of the Head Start Director and/or Special Needs Coordinator.

6. If the Health Department Guidance Clinic cannot provide the needed services, then a recommendation will be made to the Head Start Director and/or Special Needs Coordinator for an appropriate referral.

H. If travel is required in provision of treatment services on site at the Head Start facility, the health department staff will be reimbursed for preparation and travel time to the Head Start facility.

II. CONSIDERATION AND COST OF SERVICES

A. Psychological and Speech/Language and Hearing Evaluation/Assessments will be reimbursed at the rate of thirty dollars ($30.00) per hour. Covered will be:

1. Staff time spent in intake interviewing and results session with parent or other custodial caretakers;

2. Staff time spent in testing of children.

B. Individual or family counseling or parent counseling will be reimbursed at the rate of thirty dollars ($30.00) per session.

C. Psychotherapy will be in one-session increments at the rate of thirty dollars ($30.00) per session.

D. The Health Department will be paid for any consultation at the rate of thirty dollars ($30.00) per session.

E. Screening services will be billed at the rate of six dollars ($6.00) per child or thirty dollars ($30.00) per hour, whichever is less.

F. Speech, Language and/or Hearing therapy will be in half-hour session increments and will be billed at the rate of:

Per individual - $15.00 per half-hour session
Per group (each child) - $10.00 per half-hour session

G. In-Service training and/or workshops (1-2 hours) sixty dollars ($60.00) (longer workshops at comparable rates).

H. Observation and consultation services will be billed at the rate of thirty dollars ($30.00) per hour.

I. Travel will be reimbursed at the rate of twenty and a half cents ($.205) per mile.

Source : Davis, W. (1988). Oklahoma Department of Health. Unpublished material.

J. The Health Department will be reimbursed at a rate of $30.00 per hour for preparation and driving time for treatment on site at the Head Start center.

K. In order to meet the consortium guidelines, a twenty-five percent (25%) "in-kind" service will be given. The following services will be designated as "in-kind" services:

1. Secretarial services for typing required reports, handling records for registered Head Start clients
2. Billing services for Head Start clients
3. Advice on the utilization of other community resources and referrals
4. Staff time required for writing report of test results

L. The maximum amount of money allocated for the services outlined in this agreement is not to exceed eighteen hundred dollars ($1,800.00).

M. The Head Start program will reimburse the aforementioned Health Department Guidance Service on a monthly basis following the provision of services. The Health Department Guidance Services will bill monthly, detailing services provided. The names of the children who are provided evaluation/assessment and treatment services will be listed on the monthly invoice for payment.

III. DURATION OF CONTRACT

The duration of this contract is from the 1st day of September, 1989, to the 30th day of November, 1989.

IV. CANCELLATION

A. This contact is subject to termination upon thirty (30) days advance, written notice by either party. Said written notice must be forwarded by certified mail to one of the following:

Executive Director
Head Start
P.O. Box
Oklahoma

Administrative Director
Health Department
P.O. Box
Oklahoma

B. In the event that the Health Department can no longer provide all or part of the stated services, then that part or all of the contract will be cancelled.

Source : Davis, W. (1988). Oklahoma Department of Health. Unpublished material.

CONTRACT
SAMPLE - PAGE 6

V. AMENDMENTS

This contact is subject to amendment at any time, but only upon fully written consent and approval by both parties.

VI. Signed parental consent forms will be obtained before providing services to minors.

_____ _____

Executive Director, Head Start
Oklahoma — Date

_____ _____

Administrative Director, Health Department
Oklahoma — Date

_____ _____

District Coordinator
District Guidance Clinics — Date

Source: Davis, W. (1988). Oklahoma Department of Health. Unpublished material.

CONSULTATION AGREEMENT
SAMPLE

This agreement is executed by and between the Bingham Guidance Clinic, hereinafter referred to as "BCGC," and Floyd County Community Action Agency's Head Start Program, hereinafter referred to as "Head Start."

WITNESSETH:

WHEREAS, Head Start is involved in providing an educational experience designed to "bring about a greater degree of social competence in children of low income families" and desires consultation from a mental health professional to aid in achieving this goal; and

WHEREAS, BCGC has the ability to provide such consultation;

NOW, THEREFORE, it agreed by and between the parties hereto as follows:

1. The BCGC shall provide mental health consultation to the Head Start Program at the rate of $30.00/hour, up to $2,220.00, during the 1988-89 school year.

2. The type and time of such consultation shall be determined by the mutual consent of the Head Start Director, or designee, and the consultant. Areas of consultation include:

   a. Observation of each classroom twice yearly. The focus shall be on teacher-assistant interaction, adult-child interaction, and general classroom atmosphere. The consultant shall meet with the Education Coordinator following observations to make recommendations.

   b. Consultation regarding emotionally handicapped children.

   c. Identification of children with emotional adjustment problems. This will involve classroom observations and staff consultation.

   d. Implementation and evaluation of therapeutic programs for children with emotional adjustment problems. This will involve classroom observations with a written report submitted to Head Start within two (2) weeks after the scheduled observation.

   e. Consultation with Head Start teachers and staff. Southern Indiana Mental Health and Guidance Center may receive appropriate information on clients, who are also participating in Project Head Start, so long as the child's parent(s) or guardian(s) give written permission to exchange such information.

   f. Head Start reserves the right to request consultation meetings, with this being included in the consultation time contracted for.

   g. Referrals will be made to Southern Indiana Mental Health and Guidance Center, if appropriate.

Source: Indiana Mental Health Task Force. (1986). *Working together: Hand in hand.* New Albany, IN: Floyd County Head Start Program.

CONSULTATION AGREEMENT
SAMPLE - PAGE 2

h. Referrals will be made to other community agencies, if appropriate.

i. Written reports of evaluations of individual children will be submitted within two (2) weeks after they are held.

j. Planning and assistance with mental health related concerns that may arise during the year shall be provided.

3. The consultant will aid in determining the need for evaluations and will assist in either evaluating or making referrals to the appropriate agencies.

4. Compliance with requirements of the Performance Standards for Head Start Programs and development, implementation and modification of locally determined goals and objectives shall be completed jointly by the consultant and the Head Start Director, or designee.

5. Consultation services must be authorized and approved by the Head Start Director and/or her designee. The maximum amount of the contract shall be $2,200.00. However, additional services may be requested, at the rate of $30.00/hour, should additional monies become available. The BCGC will provide quarterly statements (November, February and May) for services rendered under this contract.

6. Head Start agrees to inform the consultant at least 24 hours in advance of cancellation of a scheduled meeting. The consultant agrees to inform Head Start of the same.

7. Head Start grants permission to the consultant to disclose to others that he/she is providing this consultation service to Head Start.

8. The BCGC agrees to provide supervision of the consultant's work. _____, M.D., Associate Professor of Child Psychiatry, University of Louisville School of Medicine, or his designee, will serve as supervisor.

9. This agreement shall be in effect September 1, 1988, to May 31, 1989. This agreement is subject to modification by mutual consent of both parties, or to cancellation by either party, subject to a 30-day notification.

_____ _____

Associate Professor and Executive Director — Date
Bingham Child Guidance Center

_____ _____

Director — Date
Floyd County Head Start

Source: Indiana Mental Health Task Force. (1986). *Working together: Hand in hand.* New Albany, IN: Floyd County Head Start Program.

MEMORANDUM OF UNDERSTANDING
SAMPLE

This Memorandum of Understanding, executed _____, 19___, at _____, Indiana, by and between Project Head Start of St. Joseph & Elkhart Counties, hereinafter referred to as "Head Start," and _____ hereinafter referred to as "Consultant." This memorandum serves to operationalize assessment of children enrolled in Head Start for the 1986-1987 program year, and referred for such assessment by Head Start staff.

I. RESPONSIBILITIES AND DESCRIPTION OF SERVICES TO BE PROVIDED BY CONSULTANT

A. THE CONSULTANT WILL administer appropriate cognitive assessment tests, and/or any additional psychological tests based on the referral from Head Start. Testing will be administered within fourteen (14) working days, following the Consultant's reception of the Head Start referral.

B. THE CONSULTANT WILL observe the child in the classroom center. It is understood that a trained technician may conduct the observations, under the direct supervision of the Consultant.

C. THE CONSULTANT WILL call the child's classroom on the day of the observation to ensure the child's attendance.

D. THE CONSULTANT WILL conduct a parent interview in conjunction with the child's assessment.

E. THE CONSULTANT WILL participate in a staffing of the child to be examined.

F. THE CONSULTANT WILL give recommendations and assist in securing the recommended follow-up programming as necessary.

G. THE CONSULTANT WILL provide a written report at the time of the staffing. This report will include assessment date, interpretations of this data, and recommendations for future programming/interventions.

H. THE CONSULTANT WILL complete the Diagnostic Reporting form and submit it during the staffing.

II. RESPONSIBILITIES AND DESCRIPTION Of SERVICES TO BE PROVIDED BY HEAD START

A. HEAD START WILL obtain a signed parent/guardian consent form prior to the scheduled assessment with the Consultant. A copy of the signed consent will be sent to the Consultant.

Source: Indiana Mental Health Task Force. (1986). *Working together: Hand in hand.* New Albany, IN: Floyd County Head Start Program.

B. HEAD START WILL obtain a written Mental Health Component Intake report prior to the scheduled assessment. A copy of this intake will be sent to the Consultant.

C. HEAD START WILL state a reason for initiating referral and specify services requested.

D. HEAD START WILL provide the diagnostic reporting form to be completed and returned at the time of the staffing.

III. PAYMENT PROCEDURES

A. Head Start will provide a payment of $150.00 per assessment.

B. The Consultant will submit a statement detailing services rendered.

C. All statements of amount due will be submitted to the Mental Health Component for approval.

D. The Fiscal Officer will expedite payment of the statement.

E. The Consultant may choose to pursue Medicaid approval for Medicaid eligible clients in lieu of the Head Start payment. Conditions of the contract will be met regardless of payment method.

_____ _____

Name and Title Date

Project Head Start of St. Joseph & Elkhart Counties
635 South Main Street
South Bend, IN 46601

_____ _____

Name and Title Date

_____ _____

Name and Title Date

Source: Indiana Mental Health Task Force. (1986). *Working together: Hand in hand.* New Albany, IN: Floyd County Head Start Program.

SUMMARY OF CONSULTANT'S TIME/SERVICES

SAMPLE

HEAD START AGENCY: _____

CENTER: _____

Services Rendered	I Date: No. of Hours	II Date: No. of Hours	III Date: No. of Hours	IV Date: No. of Hours
Classroom/Home-Based Socialization Observation: Individual Children				
Groups of Children				
Consultation with Staff: Individual				
Group				
Parent Conferences: Individual				
Group				
Staff Training				
Psychological Testing				
Planning and Coordination				
Other:				
Totals				

_____ _____

Consultant Signature Date

_____ _____

Authorizing Signature Date

Source: (Adapted from) Hawks, D. (1978). *The mental health consultant for Head Start* (2nd ed.). College Park, MD: University of Maryland College Center for Professional Development.

CONFIDENTIALITY GUIDELINES
SAMPLE

Particular care must be taken to protect privacy and confidentiality in serving children and their families, especially disadvantaged and/or handicapped children. Information about these children and families must be exchanged among people who serve them, both within the same agency (e.g., Head Start or mental health center) and between agencies, but: (1) no information should be exchanged except what is necessary for serving the child; (2) that information should be exchanged only with others who can be trusted to respect the right of privacy; and (3) in many instances, information legally must not be exchanged unless there is signed, written permission by the child's parent or guardian to do so.

Different agencies are bound by different laws (both federal and state), and subject to different legal liabilities, regarding maintaining confidentiality -- in addition to the ethical considerations which apply to everyone. For example, mental health centers, by law, may not give *any* information about *any* client (even the fact that that person *is* a client!) unless that client, or his/her guardian, has *within the past 60 days* given specific written, signed consent to give that specific kind of information to that specific agency or individual. This restriction is frequently a source of frustration, friction, and complication in serving the child, but it is implacable.

When a Head Start program has signed a written agreement with a mental health center (or other provider) to provide consultation services, the consultant legally functions as a member of the Head Start staff in regard to confidentiality restrictions while performing the consultation services. This means that the consultant can, without legal restriction, exchange information with other designated Head Start staff members about any child who is a subject of consultations, so long as that information was acquired through the contact of the child or family with Head Start. However, if that child or family is (or has been or becomes) a direct client of the mental health center, the mental health center (including the center's consultant to Head Start) is not legally allowed, without proper signed consent, to provide Head Start with any information given by or about the child or family directly to the mental health center. Information given to the mental health center is "owned" by the center, in other words, and the center has the legal obligation of protecting the confidentiality of that information, except when there is explicit signed consent to share it. The consultant may have knowledge of that information because of his/her other duties at the mental health center, but may not disclose that information to Head Start staff without specific signed consent. A particular example of such information is test scores.

Source : Indiana Mental Health Task Force. (1986). *Working together: Hand in hand.* New Albany, IN: Floyd County Head Start Program.

CONFIDENTIALITY GUIDELINES
SAMPLE - PAGE 2

When there are contracts or written agreements for consultation services, it is advisable to include a specification that all records concerning specific children are the property and responsibility of Head Start, although Head Start should assure convenient access, as needed, to these records by the consultant. If the consultant administers tests as part of the consultation service to Head Start children, the test protocols should be kept in the Head Start records, and Head Start assumes responsibility for protecting their confidentiality. If the child becomes a direct client of the mental health center and, in that relationship, is tested, then the test materials and their confidentiality are the property and responsibility of the mental health center; observations or interviews with child or parents must be handled in the same way.

Source : Indiana Mental Health Task Force. (1986). *Working together: Hand in hand.* New Albany, IN: Floyd County Head Start Program.

TRAINING FOR MENTAL HEALTH COORDINATOR
SAMPLE

Purpose of This Session

- Acquaint everyone with the philosophy, goals and objectives of the mental health program.
- Explain the holistic approach to mental health in Head Start.
- Explain the wellness focus of mental health. Elaborate the three areas: prevention, identification and referral, and treatment.
- Explain each individual's role in the mental health program to gain a sense of ownership of the activities.
- Introduce and explain the duties of the mental health professional.
- Provide opportunities for everyone to discuss successes and barriers to achieving mental health goals.
- Allow staff to express ideas for further training to increase their understanding of mental health and to build skills.

Suggested Topics

Below are suggested topics for training for mental health coordinators. These are especially relevant for programs which are using the mental health consultant model.

- Team Building
  - Elements of building a successful and productive team
  - Conflict identification/resolution
  - Coordination of Head Start components
- Group Process
  - Listening/support skills
  - Behavior roles within groups
- Consultation Skills
  - Description of consultation phases from entry, through identification or problem areas, to exit
  - Role of service provider/service recipient
  - Inventory of helping skills
  - Assessment of skill levels

Source: Stone, N., Pendleton, V., & Vaill, M. (1981). *Head Start mental health manuals.* (Vols. 1 & 2). Unpublished material.

TRAINING FOR MENTAL HEALTH COORDINATOR
SAMPLE - PAGE 2

- Training Skills
  - Elements of effective training
  - Characteristics of competent trainers
  - Training techniques and their appropriateness to tasks of problem solving/educating

- Child Development
  - Emotional development
  - Temperament/behavioral style
  - Social development
  - Motor development
  - Language development
  - Developmental sequences
  - Matching classroom arrangement/management to levels of child development

- Classroom/Home-Based Socialization Observation
  - Recognition of a healthy classroom climate
  - Manifestations of tension in the classroom
  - The effects of alternating teacher/child ratios
  - Active/passive learning

- Parenting
  - Individual variations
  - Family alternative styles and approaches
  - Cultural differences - values, lifestyles

- Crisis Intervention
  - Goals
  - Techniques

- Resources
  - Community resources
  - Resource inventory building
  - Networks

Training may be obtained through local colleges or universities, at workshops and training conferences, and as a part of the consultation/supervision which is provided by the mental health professional.

Source: Stone, N., Pendleton, V., & Vaill, M. (1981). *Head Start mental health manuals.* (Vols. 1 & 2). Unpublished material.

The orientation at a minimum should include:

- The history of Head Start in the community.
- Overview of intent and purpose of the program.
- Who is served by Head Start.
- Head Start regulations and policies (income, enrollment, children with disabilities, confidentiality).
- How the program is run (policy council, center committees, state funds, grantee or delegate).
- Program Performance Standards -- how all the components fit together.
- Mental Health Performance Standards and those in other components which relate to mental health (see Appendices A and B).
- Community resources being used and any current agreements.
- Mental health contacts in the community currently being used.
- Review of the current mental health plan and other plans which include mental health.
- Review of needs assessment information.
- Review of specific policies related to mental health (confidentiality, employee assistance programs, referral).
- Review of forms, paperwork, and timelines related to professional's job.
- Guidelines for communication among coordinators.
- Opportunity for questions and answers.

Source: Hansen, K. (1989). Washington, DC: Georgetown University Head Start Mental Health Project. Unpublished material.

TRAINING FOR TEACHERS AND AIDES
SAMPLE

Objectives for this training are teacher/aide competencies, attitudes, expectations and behaviors which include the following:

Objective	Guidance
An acceptance of responsibility for supporting the emotional development of all Head Start children.	
Knowledge of and increasing ability to recognize and respond appropriately to child behaviors which occur as a part of a child's response to stress.	Some children respond to stress (which has been experienced in the home or in the classroom) by becoming very active and showing great difficulty in keeping still and quiet at any time. Some children respond to stress by becoming angry and fighting with other children, or by refusing to obey the teacher. Other children may withdraw and resist taking part in the activities of the class. Helping the child to cope with the stressful situation (of a new child in the family, loss of a pet or a relative, etc.) should be part of the teacher's response to the child's behavior.
Increasing ability to recognize children's expressions of need and to use this information as a first step in developing plans for each child.	Children who are less mature will need greater reassurance, support, and personal attention than will their more "grown up" classmates. Children who receive less support at home (because of parent illness or other problems) will need more support and attention from the teacher. Children who do not speak English or who are not familiar with the culture may feel insecure with the classroom routine and may require additional support. In a classroom in which there are a number of children with special needs, plans may call for an increased number of adults (volunteers, aides) in order for each child's needs to be met.

Source: Stone, N., Pendleton, V., & Vaill, M. (1981). *Head Start mental health manuals.* (Vol. 2.). Unpublished material.

TRAINING FOR TEACHERS AND AIDES
SAMPLE - PAGE 2

Objective	Guidance
Knowledge of and experience with developmental sequences, temperaments, and coping styles which are found in normal and handicapped children in the preschool years.	"Developmental sequences" refers to the order in which children learn and achieve skills (children sit before they stand, walk before they jump, say Mama or Dada before naming their food or their toys, etc.). It is especially helpful in working with handicapped children to think of "where the child is" in these sequences (gross and fine motor, receptive and expressive language, social and emotional development) in order to know what the child should next be expected to learn.
Acceptance of individual differences in children.	This refers to the teacher's/aide's comfort with the different styles of learning and different temperaments which individual children may have. Occasionally, a teacher/aide and a child may not manage well with each other. It is as though, for some reason which is hard to explain, each seems to bring out the worst side of the other. When this happens, consideration should be given to transferring the child to another class.

Source: Stone, N., Pendleton, V., & Vaill, M. (1981). *Head Start mental health manuals.* (Vol. 2.). Unpublished material.

87

HANDOUT FOR ORIENTATION MEETING FOR STAFF*
SAMPLE

Mental Health Services for the coming year will assist teachers, administrative staff, and parents to provide developmental support for all of the children in the Head Start program. The services which will be provided are consultation, staff training, parent discussion/educatior groups and crisis intervention.

The goals of mental health services are (specify those goals you have identified for your program):

Mental Health Services Coordinator: _____

Mental Health Professional(s): _____

Consultation/Crisis Intervention

These services will be provided by: _____

Mental health consultation services will be provided at each center (or each classroom) _____ days per month in coordination with the services provided by _____ (the Education Coordinator). Classroom observation and consultation to the teacher and aides will be available. Consultation will be available in staff meetings as well. Topics for consultation will be those areas relating to the support of children's development, the maintenance of a positive classroom environment, crises involving individual children, and other topics chosen by the teaching staff.

Training

A series of _____ (#) staff training meetings relating to emotional and social development, classroom management, stress management, communication, working with parents, or related topics, can be scheduled for the coming year. Please list below the topics of special interest to you in the order of your preference. Other comments and suggestions regarding training will be welcomed also.

* Some changes in the last paragraph should be made when handout is used for parents.

Source: Stone, N., Pendleton, V., & Vaill, M. (1981). *Head Start mental health manuals.* (Vol. 2). Unpublished material.

HINTS ON OBTAINING A PROFESSIONAL FROM OTHER AGENCIES
SAMPLE

- Market the Head Start program well. It is something to be proud of.

- Decide precisely what you want and be able to clearly explain your needs.

- Be clear on what you can offer (money, mainstreamed environment, coordinated services, training opportunities, etc.).

- Determine what compromises you are willing to make.

- Use any personal connection you have to assist you in getting in the door. Rather than calling an agency blind, contact a specific individual who has been suggested to you and use your contact's name as your referral source.

- Make a personal visit to the agency and talk with the person in charge. Invite potential consultants to visit your program and visit with the parents.

- Leave information with the agency regarding your program.

- Do not give up. Keep trying. Often people are very busy but are willing to assist if you pursue them. Tell them you will call back in a week.

- Send letters to all potential service providers explaining your program and some of the services needed by Head Start families. Tell them you will call to make an appointment to visit their agency within a certain timeframe.

Source: Riley, M.T., Bucher, M., Price, J., & Tidwell, T. (1984). *Integrating mental health into Head Start: Reinforcement booklet.* Lubbock, TX: Texas Tech University.

DEPRESSION IN ADULTS
SAMPLE

WHAT IS A DEPRESSIVE DISORDER?

A depressive disorder is a "whole-body" illness, involving your body, mood, and thoughts. It affects the way you eat and sleep, the way you feel about yourself, and the way you think about things. A depressive disorder is *not* the same as a passing blue mood. It is *not* a sign of personal weakness or a condition that can be willed or wished away. People with a depressive illness cannot merely "pull themselves together" and get better. Without treatment, symptoms can last for weeks, months, or years. Appropriate treatment, however, can help most people who suffer from depression.

TYPES OF DEPRESSION

Depressive disorders come in different forms, just as do other illnesses, such as heart disease. This material briefly describes three of the most prevalent types of depressive disorders. However, within these types there are variations in the number of symptoms, their severity, and persistence.

Major depression is manifested by a combination of symptoms (see symptom list) that interfere with the ability to work, sleep, eat, and enjoy once pleasurable activities. These disabling episodes of depression can occur once, twice, or several times in a lifetime.

A less severe type of depression, *dysthymia,* involves long-term, chronic symptoms that do not disable, but keep you from functioning at "full steam" or from feeling good. Sometimes people with dysthymia also experience major depressive episodes.

Another type is *bipolar disorder,* formally called manic-depressive illness. Not nearly as prevalent as other forms of depressive disorders, bipolar disorder involves cycles of depression and elation or mania. Sometimes the mood switches are dramatic and rapid, but most often they are gradual. When in the depressed cycle, you can have any or all of the symptoms of a depressive disorder. When in the manic cycle, any or all symptoms listed under mania may be experienced. Mania often affects thinking, judgment, and social behavior in ways that cause serious problems and embarrassment. For example, unwise business or financial decisions may be made when an individual is in a manic phase. Bipolar disorder is often a chronic recurring condition.

SYMPTOMS OF DEPRESSION AND MANIA

Not everyone who is depressed or manic experiences every symptom. Some people experience a few symptoms, some many. Also, severity of symptoms varies with individuals.

Source: Alcohol, Drug Abuse, and Mental Health Administration. (1989). *Plain talk about depression* (DHHS Publication No. [ADM] 89-1639). Washington, DC.

Depression

- Persistent sad, anxious, or "empty" mood
- Feelings of hopelessness, pessimism
- Feeling of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex
- Insomnia, early-morning awakening, or oversleeping
- Appetite and/or weight loss or overeating and weight gain
- Decreased energy, fatigue, being "slowed down"
- Thoughts of death or suicide; suicide attempts
- Restlessness, irritability
- Difficulty concentrating, remembering, making decisions
- Persistent physical symptoms that do not respond to treatment such as headaches, digestive disorders, and chronic pain.

Mania

- Inappropriate elation
- Inappropriate irritability
- Severe insomnia
- Grandiose notions
- Increased talking
- Disconnected and racing thoughts
- Increased sexual desire
- Markedly increased energy
- Poor judgment
- Inappropriate social behavior

DIAGNOSTIC EVALUATION AND TREATMENT

The first step to getting appropriate treatment is a complete physical and psychological evaluation to determine whether you have a depressive illness, and if so what type you have. Certain medication as well as some medical conditions can cause symptoms of depression and the examining physician should rule out these possibilities through examination, interview, and lab tests.

A good diagnostic evaluation also will include a complete history of your symptoms, i.e., when they started, how long they have lasted, how severe they are, whether you've had them before and, if so, whether you were treated and what treatment you received. Your doctor should ask you about alcohol and drug use, and if you have thoughts about death or suicide. Further, a history should include questions about whether other family

---

Source: Alcohol, Drug Abuse, and Mental Health Administration. (1989). *Plain talk about depression* (DHHS Publication No. [ADM] 89-1639). Washington, DC.

members have had a depressive illness and, if treated, what treatments they may have received and which were effective.

Last, a diagnostic evaluation will include a mental status examination to determine if your speech or thought patterns or memory have been affected, as often happens in the case of a depressive or manic-depressive illness.

Treatment choice will depend on the outcome of the evaluation. There are a variety of antidepressant medications and psychotherapy that can be used to treat depressive disorders. Some people do well with psychotherapy, some with antidepressants. Some do best with combined treatment: medication to gain relatively quick symptom relief and psychotherapy to learn more effective ways to deal with life's problems. Depending on your diagnosis and severity of symptoms, you may be prescribed medication and/or treated with one of the several forms of psychotherapy that have proven effective for depression.

HELPING YOURSELF

Depressive disorders make you feel exhausted, worthless, helpless, and hopeless. Such negative thoughts and feelings make some people feel like giving up. It is important to realize that these negative views are part of the depression and typically do not accurately reflect your situation. Negative thinking fades as treatment begins to take effect. In the meantime:

- Do not set yourself difficult goals or take on a great deal of responsibility.
- Break large tasks into small ones, set some priorities, and do what you can as you can.
- Do not expect too much from yourself too soon as this will only increase feelings of failure.
- Try to be with other people; it is usually better than being alone.
- Participate in activities that may make you feel better.
- You might try mild exercise, going to a movie, a ballgame, or participating in religious or social activities.
- Don't overdo it or get upset if your mood is not greatly improved right away. Feeling better takes time.

Source: Alcohol, Drug Abuse, and Mental Health Administration. (1989). *Plain talk about depression* (DHHS Publication No. [ADM] 89-1639). Washington, DC.

- Do not make major life decisions, such as changing jobs, getting married or divorced, without consulting others who know you well and who have a more objective view of your situation. In any case, it is advisable to postpone important decisions until your depression has lifted.

- Do not expect to snap out of your depression. People rarely do. Help yourself as much as you can, and do not blame yourself for not being up to par.

Remember do not accept your negative thinking. It is part of the depression and will disappear as your depression responds to treatment.

FAMILY AND FRIENDS CAN HELP

Since depression can make you feel exhausted and helpless, you will want and probably need help from others. However, people who have never had a depressive disorder may not fully understand its effect. They won't mean to hurt you, but they may say and do things that do. It may help to share this material with those you most care about so they can better understand and help you.

Helping the Depressed Person

The most important thing anyone can do for the depressed person is to help him or her get appropriate diagnosis and treatment. This may involve encouraging the individual to stay with treatment until symptoms begin to abate (several weeks), or to seek different treatment if no improvement occurs. On occasion, it may require making an appointment and accompanying the depressed person to the doctor. It may also mean monitoring whether the depressed person is taking medication.

The second most important thing is to offer emotional support. This involves understanding, patience, affection, and encouragement. Engage the depressed person in conversation and listen carefully. Do not disparage feelings expressed, but point out realities and offer hope. Do not ignore remarks about suicide. Always report them to the depressed person's therapist.

Invite the depressed person for walks, outings, to the movies, and other activities. Be gently insistent if your invitation is refused. Encourage participation in some activities that once gave pleasure, such as hobbies, sports, religious or cultural activities, but do not push the depressed person to undertake too much too soon. The depressed person needs diversion and company, but too many demands can increase feelings of failure.

Do not accuse the depressed person of faking illness or of laziness, or expect him or her "to snap out of it." Eventually, with treatment, most depressed people do get better. Keep that in mind, and keep reassuring the depressed person that, with time and help, he or she will feel better.

Source: Alcohol, Drug Abuse, and Mental Health Administration. (1989). *Plain talk about depression* (DHHS Publication No. [ADM] 89-1639). Washington, DC.

SIGNS AND SYMPTOMS OF THE DEPRESSED CHILD
SAMPLE

Not only adults become depressed. Children and teenagers also may have depression. Depression is defined as an illness when it persists. Significant depression probably exists in about five percent of children and adolescents in the general population. Youngsters in hospitals and special education centers have higher rates of depression.

SIGNS AND SYMPTOMS

The behavior of depressed children and teenagers differs from the behavior of depressed adults. Child and adolescent psychiatrists advise parents to be aware of signs in their youngsters such as:

- Persistent sadness
- No longer enjoys or looks forward to favorite activities
- Increased activity or irritability
- Frequent complaints of physical illnesses such as headaches and stomach aches
- Frequent absences from school or poor performance in school
- Persistent boredom, low energy, poor concentration; or
- A major change in eating and/or sleeping patterns

A depressed child who used to play often with friends may start spending a lot of time alone. Things that were once fun may bring little joy to the depressed child, who may withdraw from previous activities. Children and adolescents who are depressed may say they want to be dead or may talk about suicide. Depressed adolescents may abuse alcohol or other drugs as a way to feel better.

Many children and adolescents who cause trouble at home or at school may actually be depressed but not know it. Because the youngster may not *seem* sad, parents and teachers may not realize that troublesome behavior is a sign of depression. Other depressed children, and sometimes their families, know about the child's depression and know that it hurts.

WHERE TO GO FOR HELP

Early diagnosis and medical treatment are essential for depressed children. For help, parents can ask their physician to refer them to a child or adolescent psychiatrist or other mental health professional, who can diagnose and treat depression in children and teenagers.

Source: American Academy of Child and Adolescent Psychiatry. (1989). *Facts for families* (No. 4). Washington, DC: Author.

SIGNS AND SYMPTOMS OF SUBSTANCE ABUSE
SAMPLE

Over the last several years, there has been rising concern about the dangers of alcohol and other drug use. The abuse of substances, legal and illegal, has dramatically affected this country. Families are torn apart, the streets of our cities have become unsafe, and our schools have been infiltrated. We must all help each other overcome the problems that alcohol and other drugs can cause.

WHAT DOES IT LOOK LIKE?

Substance	Signs and Symptoms of a User
Narcotics or Opiates-- includes heroin, morphine, codeine, demerol, dilaudid, methadone, percodan and percocet	• Sitting completely still • Vacant stare • Silly grin • Spaced out or comatose • Absent from surroundings • Complete lack of judgment • Constricted pupils
Marijuana --	• Movement slow and halting • Appears to need a great deal of effort to perform simple tasks • Appears to be daydreaming or absent-minded • Slow, slurred speech, makes unrelated statements • Impaired judgment, reaction time, motor and problem solving skills
Inhalants-- includes airplane glue, nail polish remover, lighter fluid, white-out, and gasoline	• Disoriented • Bizarre behavior • Sneezing and coughing • Impaired muscle coordination • Depressed reflexes • Unpleasant breath

Source: Fish, S. (1987). Boston, MA: Boston City Hospital. Unpublished material.

SIGNS AND SYMPTOMS OF SUBSTANCE ABUSE
SAMPLE - PAGE 2

Substance	Signs and Symptoms of a User
Hallucinogens-- includes LSD, PCP, Ecstasy and other "Designer Drugs"	• Dazed and vacant looking • Appears insane • Intellectually and emotionally disorganized • Hostile toward environment • Slurred speech • Impaired muscle coordination • Confused • Agitated • Mood swings
Stimulants-- includes amphetamines, cocaine, caffeine, nicotine	• Jumpy • Jittery • Hyperactive • Suspicious, paranoid • Focused inward while overreacting to surroundings • Sweating • Runny or stuffy nose • Dilated pupils • Hallucinating • Losing weight • Nervous • Irritable with mood swings
Alcohol --	• Slurred speech • Impaired muscle coordination • Impaired judgment • Staggering gait • Aggressive • Lethargic or out of control

WHERE TO GO FOR HELP

Many of these signs and symptoms could be signs of physical illness, intense fatigue, or other concerns. Do not jump to conclusions and assume an individual is an alcohol or other drug abuser. If possible, talk to the person about your concerns or discuss your concerns with their supervisor, the Head Start director, or mental health professional. There is extensive information on alcohol and other drug abuse. Look in the phone book under "Drug" or "Substance Abuse" for local agencies to call. The State Health Department can also assist you. See the Resource section for more references.

Source: Fish, S. (1987). Boston, MA: Boston City Hospital. Unpublished material.

CHILD ABUSE AND NEGLECT: DEFINITION AND TYPES
SAMPLE

It is frequently remarked that America is a youth-oriented culture. While this is true in many ways -- from clothing styles to choice of foods -- the fact remains that in another way Americans do not really care very much for children. One evidence of this is the size of the problem of child abuse and neglect in the United States.

Although children have always been abused and neglected, until recently the problem was considered only in terms of individual cases -- people knew "that fellow down the block is pretty hard on his kids," without realizing "that fellow" had thousands of companions. Not until the definition of the "battered child syndrome" in 1962 was significant publication and professional attention focused on the problem that ranks as one of the greatest risks to the health of our nation's children.

Since then, hundreds of thousands of cases have been opened to child protective intervention, and hundreds of studies on various aspects of the problem have been conducted. Nevertheless, child abuse and neglect remain issues difficult to define, to assess, and extremely challenging to deal with.

CHILD ABUSE AND NEGLECT DEFINITION

The Child Abuse Prevention and Treatment Act, Public Law 93-247, defines child abuse and neglect as the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 years by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby.

Abuse differs from neglect in technical terms.

Abuse means an act (or acts) by a parent (or other caregiver) directed toward a child for purposes of hurting, injuring, or destroying the child. Abuse is generally defined as an act of commission.

Neglect means failure on the part of a parent (or other caregiver) to live up to the normal role expectations in providing an environment that helps children meet normal developmental needs. Neglect is generally defined as an act of omission.

To make it simple, child abuse and neglect may be defined as any act on the part of a parent (or other caregiver) designed to destroy or inhibit normal positive growth of the child.

Source: The Resource Access Project Network. (1986). *Preventing maltreatment of children with handicaps.* Unpublished resource material.

CHILD ABUSE AND NEGLECT: DEFINITION AND TYPES SAMPLE - PAGE 2

TYPES OF CHILD ABUSE AND NEGLECT

a. *Physical Abuse:* A child who has received injuries from striking, beating, shaking or burning is physically abused.

b. *Emotional Abuse:* A child who has received psychologically harmful verbal and non-verbal messages from parents that indicate rejection, belittlement, or lack of worth is psychologically abused.

c. *Sexual Abuse:* A child who has been exploited for any sexual gratification by an adult: rape, incest, fondling, exhibitionism, and voyeurism is sexually abused.

d. *Physical Neglect:* A child who lacks the appropriate food, clothing, shelter, supervision and cleanliness expected within his/her culture is physically neglected.

e. *Emotional Neglect:* A child who has not received the appropriate psychological nurturance from parents necessary for healthy psychological growth and development is emotionally neglected.

CHARACTERISTICS OF ABUSIVE FAMILIES

We all have the capacity to strike out in anger, fear, pain, or frustration and this capability defines all of us as potential child abusers. Yet most of us are able to control these violent impulses. This profile concerns the broad categories of experience and dynamics that contribute to the abusive parent's inability to control these impulses. An increasingly comprehensive and authoritative body of literature defines seven general problem areas: 1) unfulfilled needs for nurturance and dependence; 2) fear of relationships; 3) lack of support systems; 4) marital problems; 5) life crises; 6) inability to care for or protect a child; 7) lack of nurturing child-rearing practices.

Source: The Resource Access Project Network. (1986). *Preventing maltreatment of children with handicaps.* Unpublished resource material.

CHILD ABUSE AND NEGLECT: PHYSICAL AND BEHAVIORAL INDICATORS

SAMPLE

I. PHYSICAL ABUSE

A. Physical Indicators

Unexplained bruises and welts:

____ on face, lips, mouth;
____ on torso, back, buttocks, thighs;
____ in various stages of healing;
____ clustered, forming rectangular patterns, reflecting shape of article used to inflict (electric cord, belt buckle);
____ on several different surface areas;
____ regularly appear after absence, weekend or vacation.

Unexplained fractures/dislocations:

____ to skull, nose, facial structure;
____ in various stages of healing;
____ multiple or spiral fractures;
____ bald patches on scalp.

Unexplained burns:

____ cigar, cigarette burns, especially on soles, palms, back, or buttocks;
____ patterns like electric burner, iron, etc.;
____ immersion burns (sock-like, glove-like, doughnut shape on buttocks or genitalia);
____ rope burns on arms, legs, neck or torso;
____ infected burns, indicating delay in seeking treatment.

Unexplained lacerations or abrasions:

____ to mouth, lips, gums, eyes;
____ to external genitalia;
____ in various stages of healing.
____ Other _____
_____

B. Behavioral Indicators

____ feels deserving of punishment

Behavioral extremes:

____ Aggressiveness

____ Withdrawal

____ Wary of adult contact

____ Apprehensive when other children cry

____ Frightened of parents

____ Afraid to go home

____ Reports injury by parents

____ Lies very still while surveying surroundings (infant)

____ Manipulative behavior to get attention

____ Indiscriminately seeks affection

____ Poor self-concept

____ Vacant or frozen stare

____ Responds to questions in mono-syllables

____ Inappropriate or precocious maturity

____ Capable of only superficial relationships

____ Other _____

Source: The Resource Access Project Network. (1986). *Preventing maltreatment of children with handicaps.* Unpublished resource material.

CHILD ABUSE AND NEGLECT: PHYSICAL AND BEHAVIORAL INDICATORS SAMPLE - PAGE 2

II. PHYSICAL NEGLECT

A. Physical Indicators

____ Underweight, poor growth pattern; e.g., small in stature, failure to thrive
____ Consistent lack of supervision, especially in dangerous activities or for long periods
____ Abandonment
____ Bald patches on the scalp
____ Consistent hunger, poor hygiene, inappropriate dress
____ Wasting of subcutaneous tissue
____ Unattended physical problems or medical needs
____ Abdominal distention
____ Other _____

B. Behavioral Indicators

____ Begging or stealing food
____ Rare attendance at school
____ Constant fatigue, listlessness or falling asleep in class
____ Doesn't change expression
____ Alcohol or drug abuse
____ Talks in a whisper or whine
____ States there is no caretaker
____ Extended stays at school (early arrival and late departure)
____ Delayed speech
____ Inappropriate seeking of affection
____ Assuming adult responsibilities and concerns
____ Delinquency (e.g., theft)
____ Other _____

III. SEXUAL ABUSE

A. Physical Indicators

____ Difficulty in walking or sitting
____ Pain, swelling, or itching in genital area
____ Venereal disease, especially in pre-teens
____ Pregnancy
____ Poor sphincter tone
____ Torn, stained, or bloody underclothing
____ Painful urination
____ Bruises, bleeding or lacerations in external genitalia, vaginal, or anal areas
____ Other _____

B. Behavioral Indicators

____ Unwilling to change for gym or participate in physical education class
____ Poor peer relationships
____ Delinquent or runaway
____ Change in performance in school
____ Withdrawal, fantasy, or infantile behavior
____ Sophisticated or unusual sexual behavior or knowledge
____ Reports sexual assault by caretaker
____ Other _____

Source: The Resource Access Project Network. (1986). *Preventing maltreatment of children with handicaps.* Unpublished resource material.

IV. EMOTIONAL MALTREATMENT

A. Physical Indicators

____ Speech disorders

____ Lags in physical development

____ Sallow, empty facial appearance

____ Failure to thrive

____ Hyperactive/disruptive behavior

____ Other _____

B. Behavioral Indicators

Habit Disorders:
____ Sucking
____ Biting
____ Rocking

Conduct/Learning Disorders:
____ Antisocial behavior
____ Destructive
____ Attempted suicide

Neurotic Traits:
____ Sleep disorders
____ Inhibition of play
____ Unusual fearfulness

Overly Adaptive Behavior:
____ Inappropriately adult
____ Inappropriately infantile

Behavioral Extremes:
____ Child does not change expression
____ Compliant, passive
____ Aggressive, demanding

Developmental lags:
____ Mental
____ Emotional
____ Other _____

Source: The Resource Access Project Network. (1986). *Preventing maltreatment of children with handicaps.* Unpublished resource material.

CHILD ABUSE AND NEGLECT: WHAT TO DO
SAMPLE

Identification and Reporting of Child Abuse and Neglect, Policy Instruction

Effective Date: January 26, 1977. Federal Register, Vol. 42, No. 17.

Purpose: Sets forth the policy governing the prevention, identification, treatment, and reporting of child abuse and neglect in Head Start.

Scope: Applies to all Head Start and delegate agencies that operate or propose to operate a full-year or summer Head Start program, or experimental or demonstration programs funded by Head Start.

Public Law 93-644: Requires the prevention, identification, treatment, and reporting of child abuse and neglect to be a part of the Social Services in Head Start.

In dealing with and reporting child abuse and neglect, a Head Start program will be subject to and act in accordance with the law of the STATE in which it operates whether or not that law meets the requirements of the Act. It is the intention of this policy in the interest of the protection of the children to ensure compliance with and, in some respects, to supplement state or local law, *not* to supersede it.

General Provisions:

1. Head Start agencies and delegate agencies must report child abuse and neglect in accordance with the provisions of applicable state or local law.

   a. In those states and localities with laws requiring reporting by preschool and day care staff, all Head Start agencies must comply with the local Child Abuse and Neglect reporting law.

   b. In those states and localities in which such reporting by preschool and day care staff is "permissive" under state or local law, Head Start agencies must report child abuse and neglect if applicable state or local law provides immunity from civil or criminal liability for good faith voluntary reporting.

2. Head Start agencies will preserve the confidentiality of all records pertaining to child abuse or neglect in accordance with state or local law.

3. Consistent with this policy, Head Start programs will not undertake on their own to treat cases of child abuse and neglect. Head Start programs will, on the other hand, cooperate fully with child protective service agencies in their communities and make every effort to retain in their programs children allegedly abused or neglected, recognizing that the child's participation in Head Start may be essential in assisting families with these problems.

Source : The Resource Access Project Network. (1986). *Preventing maltreatment of children with handicaps.* Unpublished resource material.

CHILD ABUSE AND NEGLECT:
WHAT TO DO
SAMPLE - PAGE 2

4. With the approval of the *policy council,* Head Start programs may wish to make a special effort to include children already meeting eligibility guidelines who are suffering from abuse or neglect, as referred by the child protective services agency. While it must be emphasized that Head Start is not expected to be a primary instrument for the treatment of child abuse and neglect, it does have an important preventive role to play in this area.

Special Provisions:

1. *Staff Responsibility*: Directors of Head Start agencies that have not already done so shall immediately designate a staff member who will have responsibility for:

   a. Establishing and maintaining cooperative relationships with the agencies providing child protective services in the community, and with any other agency to which child abuse and neglect must be reported under state law, including regular formal and informal communication with staff at all levels;

   b. Informing parents and staff of what state and local laws require in cases of child abuse and neglect;

   c. Knowing what community medical and social services are available for families with an abuse or neglect problem;

   d. Under state law reporting instances of child abuse and neglect among Head Start children;

   e. Discussing the report with the family, if it appears desirable or necessary to do so;

   f. Informing other staff about the process for identifying and reporting child abuse and neglect. (In a number of states it is a statutory requirement for professional childcare staff to report abuse and neglect. Each program should establish a procedure for identification and reporting.)

2. *Training*: Head Start agencies and delegate agencies shall provide orientation and training for staff on the identification and reporting of child abuse and neglect. They should also provide an orientation for parents on the need to prevent abuse and neglect and the need to provide protection for abused and neglected children. This ought to foster a helpful rather than a punitive attitude toward abusing or neglecting parents or caretakers.

Source : The Resource Access Project Network. (1986). *Preventing maltreatment of children with handicaps.* Unpublished resource material.

SELF-ESTEEM AND ITS EFFECTS
SAMPLE

WHAT IS IT?

Every aspect of life is influenced by self-esteem. Our beliefs and attitudes about ourselves impact on how we act, learn, relate, work and play. Self-esteem is a personal assessment of worthiness. It is a feeling that indicates the degree to which we believe ourselves to be capable, loveable, important, and successful.

High self-esteem is exemplified in persons who appear poised and confident. They generally have good social relationships, are less influenced by peers, and tend to make better decisions.

Low self-esteem may be observed in persons who feel unloved, isolated and powerless. They perceive desired goals to be unattainable and therefore may withdraw, become passive, or more aggressive.

People with high self-esteem are treated differently than those with low self-esteem due to their positive beliefs about themselves. Favorable treatment and past performance condition them to believe they will be successful in future social, academic, and professional encounters. Individuals with low self-esteem have a history of experiencing rejection and failure. Therefore, they have no belief that the future will be any different.

The spiral, regardless of its direction, perpetuates itself. The impact of self-esteem on each person's life is impossible to estimate.

WHAT ARE ITS EFFECTS?

Many studies conducted have shown that children with superior intelligence and low self-esteem may do poorly in school, while children of average intelligence but high self-esteem can be unusually successful.

School work can be a source of frustration and dissatisfaction for the child with low self-esteem. There are many reasons for this but in part it is the result of the child being easily distracted by anxieties related to relationships with others, stress, and fears. These anxieties detract from the child's ability to focus on learning activities. As a child grows and matures to adolescence, these distractions become especially strong when peer pressure and uncertainties about body image assume an overwhelming importance. For adults with low self-esteem they often experience poor interpersonal relationships, low personal satisfaction in professional and social efforts.

Source: Clems, H., & Beam, R. (1981). *Self-esteem: The key to your child's wellbeing.* New York, NY: G.P. Putnam.

SELF-ESTEEM AND ITS EFFECTS
SAMPLE - PAGE 2

HOW DO WE RECOGNIZE IT?

For individuals concerned about mental health it is important to assist individuals in achieving high self-esteem. High self-esteem will assist children in growing up to be content and responsible adults.

Because self-esteem goes up and down, it is impossible to focus on single characteristics or behaviors. Patterns of behavior over time provide clues.

Over time, a person with...

High self-esteem will --	Low self-esteem will --
• Be proud of his or her accomplishments	• Avoid situations that cause anxiety
• Assume responsibility	• Demean his or her own talents (put themselves down)
• Tolerate frustration	• Blame others for own failings
• Approach new situations with enthusiasm	• Be easily influenced by others
• Show a broad range of emotions and feelings	• Be defensive and easily frustrated
	• Feel powerless

Self-esteem is also determined not only by how we feel about ourselves, but also by what others tell us about ourselves and how they treat us. It is also determined by other effects of our environment. Therefore, living and learning environments need to be created that protect and enhance high self-esteem.

Source: Clems, H., & Beam, R. (1981). *Self-esteem: The key to your child's wellbeing.* New York, NY: G.P. Putnam.

PART II
REFERENCES

Alcohol, Drug Abuse, and Mental Health Administration. (1989). *Plain talk about depression* (DHHS Publication No. [ADM] 89-1639). Washington, DC.

American Academy of Child and Adolescent Psychiatry. (1989). *Facts for families* (No. 4). Washington, DC: Author.

Clems, H., & Beam, R. (1981). *Self-esteem: The key to your child's wellbeing.* New York, NY: G.P. Putnam.

Cross, T.L., Bazron, B.J., Dennis, K.W., & Isaacs, M.R. (1989). *Towards a culturally competent system of care. A monograph on effective services for minority children who are severely emotionally disturbed.* Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

Davis, W. (1988). Oklahoma Department of Health. Unpublished material.

Fish, S. (1987). Boston, MA: Boston City Hospital. Unpublished material.

Hansen, K. (1988). Washington, DC: Georgetown University Head Start Mental Health Project. Unpublished material.

Hawks, D. (1978). *The mental health consultant for Head Start* (2nd ed.). College Park, MD: University of Maryland College Center for Professional Development.

Indiana Mental Health Task Force. (1986). *Working together: Hand in hand.* New Albany, IN: Floyd County Head Start Program.

The Resource Access Project Network. (1986). *Preventing maltreatment of children with handicaps.* Unpublished resource material.

Riley, M.T., Bucher, M., Price, J., & Tidwell, T. (1984). *Integrating mental health into Head Start: Reinforcement booklet.* Lubbock, TX: Texas Tech University.

Seabolt, N. (1979). *Mental health services in Head Start: A guide to implementing the mental health objectives and performance standards.* Kansas City, MO: Community Development Institute.

Stone, N., Pendleton, V., & Vaill, M. (1981). *Head Start mental health manuals* (Vols. 1 & 2). Unpublished material.

PART III
FIVE-STEP PROCESS FOR PLANNING THE MENTAL HEALTH PROGRAM

As the mental health coordinator, you provide focus, direction, and energy to the planning process. One of your major responsibilities each year is to work with the mental health professional and others to revise and rewrite the mental health component plan. Head Start component plans commonly begin with a narrative section which describes:

- Program and component philosophies
- Overall mental health objectives
- Summary of the needs assessment process and established needs of the staff, parents, and children
- Community characteristics
- Staffing model and reason for the choice
- Methods used to yearly evaluate the plan and revise it

Usually, the plan also contains a chart format which describes:

- Problems to be addressed
- Performance standards related to the problems
- Goals related to the problems
- Activities to be completed
- Staff responsible for the activity
- Time lines
- Methods of documentation
- Evaluation strategies for each activity

This manual gives you strategies for obtaining the information for the narrative portion of the plan and provides for your own use an example of a chart for activities. (See *SAMPLES* for *Key Elements of a Mental Health Plan* and *Head Start Mental Health Plan: Blank Format.*)

To begin this planning process, it is important to establish a planning team. Since mental health encompasses all components, every component coordinator should be invited. The group should be limited to a small number of people and should reflect a range of perspectives; for example, a head teacher, a social services worker, the mental health professional, and a parent volunteer. Reserve the right to determine the final composition of the planning team.

This diversity will help ensure that the plan reflects the attitudes of everyone in the program and that the overall mental health objectives are appropriate. These objectives will be derived from the Mental Health Performance Standards Objectives and other component objectives related to mental health. The team may want to create separate objectives for staff and parents. (See Part I: "Mental Health Performance Objectives.")

People need to recognize that they have common concerns and interests in the area of mental health. The objectives are best set by a group familiar with the range of resources and problems of the program as well as of the community. If there is consensus on what targets you are aiming for, then it will be easier to get support for the activities you plan and assistance in collecting data needed to document progress.

Throughout the year, your group should evaluate the activities in the plan once they are completed and modify the plan as needed. At the end of the year, the planning team should examine the total plan and decide how well the philosophies and overall objectives were carried through into activities and were translated into the best possible services for enrolled children and their families. If the philosophies and objectives do not match the activities, re-evaluate the plan and make modifications.

In all planning efforts, whether routine or complex, there are five basic steps:

1. Establish a philosophy
2. Gather information
3. Develop the plan
4. Implement the plan
5. Evaluate the plan

STEP ONE: ESTABLISHING A PHILOSOPHY

(This section is adapted from Hagenstein, A. & Antes, M. (1986). *Management action plan: A blueprint for Head Start coordinators.* Newton, MA: New England Management Center, Education Development Center, Inc.)

WHY IS IT IMPORTANT TO HAVE A PHILOSOPHY?

A philosophy of mental health guides everyday interaction and determines how the plans for day-to-day work are carried out. A philosophy is probably already at work in your Head Start program, but it needs to be clearly set out and conveyed to all employees and parents. This avoids confusion and strengthens the focus on mental health throughout the program.

A clearly articulated philosophy can:

- Guide policy -- A philosophy of positive self-concept for children results in a discipline policy stressing positive redirection.

- Provide guidelines for interviewing, selecting, and orienting new staff -- Head Start staff must work toward mutually agreed upon goals. The philosophy statement can provide a yardstick against which to measure prospective staff's views on mental health and a way to orient them in the program.

- Serve as a touchstone -- Do the actions and attitudes of everyone in the program really support the philosophy?

The time and effort you, the entire staff, and parents spend articulating a philosophy for the component -- one that reflects the uniqueness of your community and your program -- will pay dividends in the long run by improving performance and services to families and children.

PROGRAM AND COMPONENT PHILOSOPHY

Each Head Start program is based on a philosophy which comes from the Head Start Performance Standards and from the experience and expertise of its staff. A program director is responsible for articulating overall program philosophy. However, the development of a philosophy, as well as its review on a regular basis, should be a team effort; the director should solicit input from component coordinators in addition to other key staff, parents, and community representatives. When people are clear about why they do what they do, their behavior is likely to conform to program standards. They also will feel a sense of ownership in the work they do.

Whereas program philosophy will focus on broad issues that encompass all services which the program provides, component philosophy will reflect how that global view is played out in the mental health area. The mental health component philosophy must be in agreement with the overall program philosophy, but it also focuses directly on specific content issues. For example, if the program philosophy includes a statement about encouraging the social-emotional development of children, the education component philosophy might choose to state the importance of doing most activities in small groups to strengthen friendship skills. Then the parent involvement philosophy might elect to build parent skills through training on normal child development. The social services philosophy might explain why helping families utilize community resources can increase the social-emotional development of all the members of the families. In this case, the mental health philosophy might describe why a holistic wellness approach to helping families encourages social-emotional development.

Prior to the first meeting of the planning team, review and distribute copies of the program's general philosophy and the Head Start Performance Standards, so that team members can read through them. Be sure that they understand that component philosophy must be in agreement with both. Then, during the meeting, brainstorm ideas and develop the key elements to be contained in the component philosophy. (See *SAMPLES* for *Planning Team Meeting* and *Mental Health Philosophy Worksheet.*)

The actual work of writing up the statement is most productively performed by one person. Aim for simplicity and brevity -- more than one page will defeat the purpose, which is to have an easily understood and well-focused set of beliefs that tell people why you do what you do.

The draft should first be reviewed by the planning team members, and then by the Parent Policy Council and staff who had not been involved in the process, as well as by the agency board. It is important that the philosophy have a broad base of support because, as the foundation of the whole mental health program, it guides actions, determines plans, and provides direction for everyone involved (Hagenstein, 1986).

STEP TWO: GATHERING INFORMATION

It is critical that you think of assessment as a means of identifying the unique character of your program. It is the valuation of all that you have done. The interrelationship between your philosophy, this step, and evaluation (Step Five) is very tightly woven. Your assessment of needs will be only as valid and accurate as the information you have gathered through your evaluation methods.

Assessment begins with putting together all the knowledge available about the mental health needs of staff, parents, and children as well as information about resources in the community.

ASSESS NEEDS OF STAFF, PARENTS, AND CHILDREN

The mental health of individual staff must be assessed. Staff are working directly with children, families, and their colleagues. Staff needs may fall into five categories.

Need for a supportive work environment.

> Staff morale, working conditions, management and leadership style of supervisors as well as other factors contribute to how staff feel about their work environment.

Need for individual mental health support.

> Staff may suffer from many of the same needs as the families they serve: low self-esteem, drug dependency, poor interpersonal skills, history of being abused or abusing their own children, poor problem-solving skills, low education accomplishment, financial difficulties.

Assistance in understanding the mental health needs of children and families.

> It is critical to assess staff knowledge about normal child development and ways to foster the development of self-esteem in children. Staff must respond to children in ways that facilitate children's development of a positive self-concept.

Comprehension of their role in implementing the mental health program.

> Often confusion over roles and responsibilities leads to an ineffective program. Assess individual staff needs as related to their understanding of their role.

Need for individual skill development in the area of mental health.

> It is important to determine if all staff possess a clear understanding of the goals and objectives of the mental health program. In addition, assessment of skill areas and particular topics of interest will assist you in determining training needs.

Assessment in these areas should be an agency endeavor. Assistance from your director and the other component coordinators is essential. This information can be gathered through personal interviews, surveys, observation, and performance evaluation. Needs of staff are of high priority as they are the foundation of the entire mental health program.

> Where to Begin?

1. Supervisors of staff must review performance evaluations to determine individual needs and to decide if there are several staff members with similar needs.

2. Review staff evaluations of the mental health program for previous years.

3. Have staff develop a "needs" list that includes: training, materials, use of the mental health consultant and of others as necessary to implement the mental health plan.

It is important to establish priority areas of focus for the coming year or for the next several years by determining how parents evaluate last year's mental health plan and by reviewing the information learned from needs assessments of incoming families and from various enrollment forms. For example, if you have a large number of teenage mothers in your program, you will want to determine common mental health concerns, design strategies to address them in Head Start, and ascertain what services are available to teenage mothers in the community that meet those needs.

Other examples of determining the needs of parents would be identifying: a high number of families in which problem-solving and coping skills are inadequate; families in which substance abuse is a problem; families in which English is not spoken; families needing assistance in becoming employable; and families who find themselves isolated from friends and extended family members. Many more examples can be cited; the important point is to learn the needs of your parent population.

Where to Begin? With the Parent Involvement/Social Services Coordinator --

1. Review evaluations from last year's parent activities and meetings. Look for: a) those things that weren't accomplished last year; b) what you want to expand; c) what you want to eliminate.

2. Review all forms, i.e., enrollment forms, the family needs assessment, and health forms to determine the mental health needs of the family and of individual family members. Look at forms and talk to other component coordinators about common issues of: employment, health, emotional concerns, needed parenting skills, requests for support. (See *SAMPLES* for *Parent Interest Survey.*)

3. Establish a prioritized list of family needs.

The needs of children must be considered within the context of the family and the surrounding environment. Therefore, careful assessment of families, their strengths, their needs, and the children's role within them will provide you with valuable information about the children's needs.

Individual developmental screening, parent report, teacher observation, and outside referral information will provide specific data that will enable you to do an overall assessment of the needs of enrolled children.

Where to Begin? With the Education/Disabilities Coordinator --

1. Review all enrollment forms.
2. Review family assessment information.
3. Review formal screening results.
4. Solicit parent information about their children's needs.
5. Solicit teacher/aide assessment of needs.
6. Review education curriculum and materials.
7. Review health forms and health screening results with the health coordinator.
8. Determine the priority needs of the children.

INVESTIGATE COMMUNITY RESOURCES

In order to better serve staff, children, and parents, it is essential to know the existing mental health resources in your community. In many communities there are resource publications and lists which may have the needed information and save you time. If you are new to Head Start, review the mental health plan in the most recent grant application to see if community resource information is available. Work with the social services coordinator to update current lists or gather new data.

In rural areas service providers may be difficult to find and you may have to call providers in each of the areas served. Call all the providers you can think of and ask them if they know of anyone who may be able to assist. There is often a network of people who know each other and can help. Call schools, hospitals, clinics, community centers, churches, community care homes (they may be using mental health services), and community colleges.

When assessing mental health resources for use by families, you want to know, at a minimum, the following information (see *SAMPLES* for *Mental Health Center Questionnaire*):

- Contact person
- Service provided
- Eligibility criteria for each service
- Method by which the service is provided
- Cost per service
- Payment options
- Availability of each service (waiting list)

As you discuss services with these community resources, assess their capability as providers of mental health consultation to your program. It would also be helpful to know if they have the capacity to provide in-service training. Ask them to identify topics, cost, and availability.

Where to Begin? With the Social Services Coordinator --

1. Review evaluations done by families when referred to various agencies.
2. Review existing referral files and update them by telephone interview or mailed questionnaire.
3. Call the United Way and other funding agencies to determine if they have funded any new programs in your area.
4. Call professional organizations to update the list of private providers.
5. Contact the local school district to determine any changes in service provision for the coming year.

As you and the other component coordinators survey the community for resources, you will discover gaps in services that exist. It is important to document these gaps and, as a group, decide what advocacy role is appropriate to play. Head Start's Social Services Advisory Committee and Health Advisory Committee can be of vital assistance.

ANALYZE THE INFORMATION

Now that you have all the available information assembled in front of you, it's time to begin the process of making some sense out of it. This may seem a bit overwhelming, but some initial organization will help. There are three questions to ask:

Do you have the information you need to determine goals?

It is important to determine gaps in information and try to obtain the missing pieces. Sometimes this is not possible because the information was never collected as part of the evaluation process. Identify the missing pieces and develop a system within your agency and/or community for making sure that this information will be available to you in the future.

Is the information you have accurate?

Having a lot of information does not mean that it is accurate. How old is the information? What method was used to calculate the results? Was the information skewed because of language or cultural barriers?

Is the information you have useful?

Not all information you have gathered is useful for your purposes. Useful information is whatever provides you with insights into the unique characteristics of your families, staff, and community; data that can be translated into overall objectives, specific goals, and activities. Develop a file of useful data that is easily accessible. Put the remainder of the information aside for the time being; it may have other uses.

When you have finished this analysis, if you do not have the needed information to begin establishing overall objectives and specific activities, try the strategies listed below.

1. *Data.* You may find additional information in the Program Information Report (PIR), the Self-Assessment Validation Inventory (SAVI), enrollment forms, health forms, children's screening information, evaluations of activities, budget considerations, staff skills, and other sources that may be available to you.

2. *"Key Person" Interviews.* These interviews will give you a strong sense of those things individuals in your program and your community consider to be important. You would ask these individuals what major mental health concerns they feel need to be addressed and whether they would be willing to assist in an effort to meet identified needs. If they are willing to assist, it would be helpful to find out how they are willing to help: money, time, materials, or other. Individuals in this group might include: parents, policy council members, the community mental health center director, the local elementary school principals, leaders of local mental health projects such as rape crisis centers or centers that assist immigrants or other foreign nationals, your teachers, your fellow coordinators, PTA presidents, leaders of special interest groups (Association of Retarded Children/Citizens, United Cerebral Palsy Association), other disability-focused groups, interested university personnel, political action groups in your community, neighborhood watch organizers, and others. Your task is to find the people "in the know" in your community and your program.

3. *Surveys.* Surveys can bring you closer to the problem when you conduct them with people directly affected by your initiatives. Survey parents, staff, community leaders, and agencies. The information obtained from these and other sources will provide you with your baseline- "before"-information. Retain them in your files for end-of-year evaluation. Use them NOW to develop goals and objectives.

ORGANIZE NEW INFORMATION

Now that you have sorted out the useful information from the irrelevant and possibly gathered additional information, you are ready to assemble the data in a useful form.

1. Begin by prioritizing the needs identified for parents, staff, and children.

   Write these needs in the form of a problem using numbers or percentages, if possible. This will assist in making the results of an activity measurable. Categorize the needs into the areas of prevention, identification and referral, and treatment, when pertinent. This will assist you in providing appropriate activities. (See *SAMPLES* for *Strategy Sheet for Implementing a Preventive Mental Health Program.*)

Below is an example of a need to help parents become comfortable with identification and referral procedures. We will follow this example into the planning and evaluation steps.

Example:

PROBLEM

Parents: 25% of the parents refuse to sign permission slips to have their child observed by the mental health professional when deemed necessary.

2. Determine what you have in place to meet the prioritized needs.

   - personnel available
   - space
   - time
   - desire
   - materials
   - supports internally and in the community
   - money

3. Determine what additional resources are necessary in order to meet each of the high priority needs.

REVIEW LAST YEAR'S PLAN

Before you sit down and actually write this year's plan, you should review information from last year's mental health program. Look at your staffing model and establish if it is the best one to meet the identified needs given your fiscal and personnel constraints. Part II: Mental Health Is Everybody's Business provides several alternative models. Make changes, if necessary.

You should also look at your last year's plan to decide if the program met:

- Local, regional, and national requirements -- Did you meet established criteria and minimum requirements?

- Your overall component objectives -- Were they relevant and realistic?

- Your activity goals -- Were they successful and did they fulfill a need? Should they be included in the new plan?

- The "stranger test" -- Could a new staff person easily understand the plan and know how to carry it out step by step?

Last, you need to take a realistic look at the program's limitations. From the assessment process you now have a clear picture of these limitations in the following areas: staff expertise, staff availability, number of months the program operates, daily program structure, parent time, and budget. This final look helps you to develop a plan which will work for the staff, parents, and children without causing stress and burnout. It can allow everyone to feel successful and involved in the mental health component.

STEP THREE: DEVELOPING THE PLAN

Now that you are armed with information, you're ready to design activities and fill in the activities chart of the plan. This chart defines the actual activities which will be performed to meet the overall objectives, carry out the program and component philosophies, and meet the needs established through the assessment process.

Component plans are designed by local programs. The National Head Start Office does not require a standard format for plans. It does, however, encourage designing plans that are referenced to the performance standards, that will be useful, and that are easy to read. Check with your regional office staff for regional requirements.

A useful plan will reference the performance standards:

- For each action, identify the performance standard(s) to which it relates.
- For each action, identify the performance standard(s) in other components to which it relates.

We have established a sample chart which contains the problem statement and six columns.

HEAD START MENTAL HEALTH PLAN

PROBLEM STATEMENT: _____

GOAL PERFORMANCE STANDARD	ACTIVITY	RESPONSIBILITY 1=Lead 2=Assist	TIME LINE (Jan - Dec)	DOCUMENTATION	EVALUATION

(See *SAMPLES* for *Head Start Mental Health Plan: Activities* and *Blank Format* for your use.)

The columns of the plan record the following:

- Problem Statement -- Problem as defined by the needs assessment. State in numbers or percentages, if possible, for easier evaluation of results.
- Specific Goal -- What do you want to happen to solve the stated problem?
- Performance Standard -- What performance standard does the problem relate to?
- Activity -- What activity is planned to address the problem?
- Responsibility -- Which staff will take the primary and secondary responsibility for completing the activity?
- Time Line -- During which months or specific dates will the activity take place?
- Documentation -- How can you show that the activity actually happened?
- Evaluation -- What method will be used to decide if the activity was successful?

DRAFT THE PROBLEM STATEMENT

The problem statements have already been isolated during the process of assessing and prioritizing needs. Fill in the problem statement of the plan with those problems you can most realistically address. Don't neglect any facet of the Head Start population (staff, parents, and children) as you create problem statements.

Example:

PROBLEM

Parents: 25% of the parents refuse to sign permission slips to have their child observed by the mental health professional when deemed necessary.

CORRELATE GOAL AND PERFORMANCE STANDARD

Goals should be written after careful assessment of available resources and constraints. Set goals that are clear, meaningful, achievable, and directly related to your problem statement.

Some helpful hints for goal setting (adapted from *A Guide for Education Coordinators in Head Start*) are:

- Make them useful. Will this help the target group?
- Make them realistic. Will these be possible to accomplish?
- Make them clear. Will they be understood by anyone who reads them?
- Make them measurable. How will you know if the goal is achieved?
- Make them responsive to the performance standards, self-assessment, and external evaluation results. Did you use all the information available?
- Make them compatible with other components. How have you integrated and coordinated mental health efforts and activities?

Write in the performance standard which most accurately reflects the goal. This will help assure that all the Mental Health Performance Standards are addressed.

Example:

GOAL

Parents: That 100% of the parents understand the purpose of observation and sign the permission slips to have their child observed.

PERFORMANCE STANDARD

1304.3-8(b)(6) -- Parental consent for special mental health services.

DETERMINE ACTIVITIES, RESPONSIBILITIES AND TIME LINE

These categories relate directly to each other and specifically address the problem statement.

Activities detail what you are going to do; where you are going to do it; who will be the target of your actions.

Responsibility designates who the primary and secondary parties responsible for the activities will be.

Time Line sets out when and how often the activities will take place.

Example:

ACTIVITY	RESPONSIBILITY 1=Lead 2=Assist	TIME LINE (Jan - Dec)
In the parent orientation, have the mental health professional explain the observation process.	PIC = 1 MHC = 2	August
At a parent meeting, use available media to discuss mental health (videos, literature).	PIC = 1 MHC = 2	January
If the parents do not want to sign slips, the mental health professional and/or coordinator will visit the family.	MHC = 1 PIC = 2	August - May

PIC = Parent Involvement Coordinator
MHC = Mental Health Coordinator

ESTABLISH DOCUMENTATION PROCEDURE

These are the measurable results of what actually happened related to the activity. For example, how many parent meetings were held, how many parents came, how many people responded to your survey, how many staff meetings were held, how many children were screened for social-emotional considerations, how many people were referred for service, how many people who were referred for services used them. Documentation will be further discussed in Step Five: Evaluation.

Example:

DOCUMENTATION

Activity 1: Orientation agenda
Parent sign-in sheet for orientation

Activity 2: Parent sign-in sheet for meeting
Agenda for meeting

Activity 3: Report on visits to family

PLAN FOR EVALUATION

Evaluation describes what methods will be used to evaluate the results and effectiveness of the completed activity.

Example:

EVALUATION

Activity 1: Parent evaluation form on meeting
Number of parents signing mental health consultation form

Activity 2: Parent evaluation form on meeting
Number of parents signing mental health consultation slips

This chart format contains the essential elements of the activity portion of the plan and is only an example of how that portion can look. Please feel free to adapt or change it to meet your program's needs and requirements.

STEP FOUR: IMPLEMENTING THE PLAN

Implementation is a joint staff and parent effort. Your planning team will aid you during the implementation of your plan. If you look over your plan you can see that you are not in this alone. Look at the column for "Responsibility" and you will notice that you have a lot of intercomponent support for your plan.

Given the wide range of your responsibilities, it is imperative that you are comfortable with the plan you have developed and can explain it to others with logical justifications for its content, when necessary. If you do not understand the plan yourself, it will be very difficult for you to provide the leadership necessary to facilitate it. Since you are ultimately responsible for its implementation, it is to your advantage to have developed a manageable, well-integrated plan.

In Part II: Mental Health Is Everybody's Business, we explain your responsibilities as they are listed in the performance standards. Listed below are general responsibilities related to the implementation of the plan.

- Convene meetings of the planning team. A meeting at the beginning and one at the end of the year to evaluate the plan and review objectives are essential.

- Establish or review the mental health component philosophy with the planning team.

- Take responsibility for writing the component philosophy and distributing it to all staff.

- Work with other component coordinators to develop an integrated needs assessment process. You will be primarily responsible for making sure questions are asked regarding mental health and that mental health resources in the community are contacted.

- Write the plan. You will work with the planning team to gather the information, but the actual writing is your job. You should also distribute the draft to the team for input before you submit it to the director for approval.

- Promote a commitment to and an understanding of the mental health component plan among all program staff. Part I of this manual, Mental Health and Head Start: A Perfect Fit, provides you with clear information on the scope and intent of the mental health program in Head Start.

- Orient parents and staff to the objectives of the mental health program. Orientation to the mental health program in your agency is perhaps one of the most important tasks you and the director have. It sets the tone for the year. Orientation must address people's fears, anxieties, pre-conceived notions, and values. There must be clear guidance and support related to the objectives of the program.

- Coordinate the tracking of mental health related activities in all components. Often the other components do not perceive that some of their activities are mental health activities. (See Appendix B for those performance standards which detail mental health activities for other components.) Therefore, careful team planning at the beginning of the year to identify mental health activities in the entire program is essential to developing a tracking system.

- Anticipate the unexpected. Many more unforeseen problems come up during the year. Your ability to solve problems and develop clear options related to what the program can do and what the program limitations are is very important. Try to utilize the resources at hand, access colleagues in other programs for information and any experience they may have had with a similar program, and, above all, involve others in the decision-making process to facilitate implementation of the action steps.

One of the ways to anticipate problems is to create a scenario or situation and have staff brainstorm action steps that could be taken. Examining alternatives and being comfortable with discussing potential problems makes them easier to face. If you are interested in doing this, see *SAMPLES Situation Practice Sheet* for some scenarios at the end of this part.

STEP FIVE: EVALUATION

With all the problems in society today, there is a tremendous interest in mental health issues facing young children and their families. A variety of groups are concerned that these issues come to the forefront of early childhood program planning. Evaluative evidence that your intervention strategies work, that they have a positive impact, and that they are effective must be provided. An effective evaluation will examine how your efforts aided each of the target populations: parents, staff, and children. Remember, an evaluation is no good if it does not help decide the future of the program. Any evaluation, however simple and direct, which provides the necessary answers to enable you to chart the future of your efforts is a satisfactory design.

A number of valid reasons exist for carefully completing this evaluation process. You and the planning team members put a lot of hours and thought into the plan. Through an accurate evaluation you can:

- Improve your program
- Validate your success
- Answer questions about the program's effectiveness
- Provide information that can be used to plan improvements or changes in the program
- Help make decisions about the program's future
- Validate funding proposals
- Win the support of bosses, colleagues, families, policy makers, and the community

When you convene the team to evaluate the planning process, you may wish to discuss:

- How well did the overall objectives established for the component match the philosophy and relate to the planned activities?
  - Did the needs assessment process yield the appropriate information? If not, why not?
  - Some barriers may have been: personnel issues, not enough time, insufficient funding, language barriers, cultural barriers, or inadequate information available. How did these affect the planning process?
- How effective was your planning process? Were there enough meetings? Make-up of the planning team?
  - List the strengths of the process.
- How effective were the activities?
  - Did the activity as designed meet the goal?
  - Did you have the right person doing the activity?
  - Was the timing good -- both time of year and time of day? Was the location appropriate; non-threatening, accessible, suitable for the activity?
- How well did the documentation process work?
  - Did the documentation do the job?
  - Are there better methods of documentation?
- How effective were your evaluation methods?
  - Were outcomes measurable?
  - Was a follow-up method utilized that was effective?

- Was there a way to record behavioral observations of participants?

    - Body language of participants: bored, engaged, timid, and other
    - Attendance
    - Participation

- What tracking and monitoring systems exist for mental health activities carried out throughout the entire program?

    - Are they effective?

    - Do they provide you with the information you need to make informed decisions for the future? (See *SAMPLES* for *Program Assessment for the Mental Health Component.*)

CONCLUSION

The five-step planning process offers a skeleton structure on which you can build a strong mental health component for your Head Start program, one that is responsive to the needs of your staff, parents, and children. With the help of others, you can create a program which promotes the wellness of each individual and can have far-reaching effects on the happiness and productiveness of all those involved.

As mental health coordinator, it is your task to energize, encourage, and enable -- the 3 E's — your colleagues, parents, and the community to help you promote wellness. You are the manager and the catalyst to change. You can accomplish the 3 E's through a positive, collaboratively developed, and well-planned approach to mental health.

PART III

SAMPLES

The *SAMPLES* provide you with additional information and forms which will help you plan, document, and evaluate your mental health efforts. They include ideas for conducting a meeting on developing a component philosophy, examples of questionnaires to use during the needs assessment process, a strategy planning format, and a filled-in activity planning chart as well as a blank one. A practice problem-solving sheet and questions for evaluating the mental health program give you formats for planning. These samples can be copied and/or adapted for your specific needs.

KEY ELEMENTS OF A MENTAL HEALTH PLAN
SAMPLE

I. Joint Planning Team

II. Background Information
- A. Summary of community characteristics and needs
- B. Summary of staff needs
- C. Summary of parent needs
- D. Summary of children's needs
- E. Summary of last year's program -- strengths, accomplishments, and unsuccessful efforts

III. Program Staffing Model
- A. Option selected
- B. Rationale for selection

IV. Philosophy
- A. Program
- B. Component -- brief statement related to staff, parents, and children

V. Overall Mental Health Objectives

VI. Stated Problem or Need and Related Performance Standard

VII. Goals and Specific Activities

VIII. Staff Responsibilities

IX. Time Lines

X. Documentation

XI. Evaluation Methods

Source: Hansen, K., & Martner, J. (1989). Washington, DC: Georgetown University Head Start Mental Health Project. Unpublished material.

PLANNING TEAM MEETING: DEVELOPING A MENTAL HEALTH COMPONENT PHILOSOPHY

SAMPLE

Note: Have available newsprint and magic marker or chalk and a chalkboard.

Begin the planning meeting by stating your goal for the meeting: "I feel that we can all benefit from working together to define our mental health component philosophy. By the end of this meeting I hope that we will have agreed on what should go into a statement of philosophy. I will then take our ideas and put them into written form."

Next, briefly review the program's statement of philosophy, if available, and the performance standards, highlighting sections that are particularly applicable in all components to mental health.

Next, ask group members to take a few minutes to complete the Philosophy Worksheet. Explain that the sheets will not be handed in, but will be used to generate ideas for the group to consider.

Allow five or ten minutes for people to complete the worksheet. Then explain to group members that together you will brainstorm a list of ideas based on what they have just jotted down.

In brainstorming, any and *all* ideas are listed on newsprint or chalkboard without being discussed or evaluated. The point is to give permission for everyone to make suggestions in a safe environment without fear of having them rejected.

After all the ideas have been recorded, it is time to discuss, evaluate, eliminate, or combine them. Allow time for ideas to incubate. Write the ideas into a series of broad statements and put them in logical order with the most comprehensive first. Be sure the statements are your philosophy and not your goals; they should fit a sentence that begins with "We believe..."

Source: Hagenstein, A., & Antes, M. (1986). *Management action plan: A blueprint for Head Start coordinators.* Newton, MA: New England Management Center, Education Development Center, Inc.

MENTAL HEALTH PHILOSOPHY WORKSHEET
SAMPLE

Please use this worksheet to jot down your ideas for completing the statements below. As a member of the planning team, try to keep in mind all of the services of the mental health component, not just your own job.

I believe that the services that the mental health program provides to children and families are important because:

The unique mental health needs of our community are:

In order to develop and grow, our children need:

In order to provide for the well-being of their children and themselves, parents need:

In order to provide for the well-being of the children in the program and themselves, staff need:

Source: (Adapted from) Hagenstein, A., & Antes, M. (1986). *Management action plan: A blueprint for Head Start coordinators.* Newton, MA: New England Management Center, Education Development Center, Inc.

PARENT INTEREST SURVEY
SAMPLE

NAME_____ PHONE_____ CENTER_____ DATE _____

INFORMATION

I am interested in KNOWING more about the items below for informational purposes (through programs at parent meetings, handouts, newsletter articles, etc.)

____ Raising self-esteem or self-confidence
____ Step-parenting and blended families
____ Divorce and custody rights
____ One-parent homes
____ Working mothers
____ Father's role
____ Domestic violence
____ Assertiveness skills
____ Planning a family budget
____ Dealing with stress
____ Community resources
____ Tenant rights/legal rights
____ Planned Parenthood
____ et and exercise
____ Kindergarten transitioning
____ Special needs children
____ Child development
____ Health and home safety for children
____ Protecting children from "bad" people
____ Dental hygiene
____ Choosing books, records, play materials
____ Special concerns: Sleeping ____, eating ____, bad language ____, sibling rivalry ____, bedwetting ____, children's fears ____
____ Other_____

VOLUNTEER

Please list below any talents or skills you would like to share with the Center.

Are you bilingual? Yes___ No___

If YES, what language? _____

Do you have transportation? Yes___ No___

Please list fun activities you would like to do with other Head Start parents:

I am willing to COMMIT the following amount of time to my Head Start Center.

_____ hours per month

I am willing to volunteer in the following areas:

____ classroom
____ food services
____ field trips
____ office work
____ parties
____ fund raisers
____ classroom material prep at home
____ equipment and center repairs
____ babysitting for other parents
____ Other _____

Source: (Adapted from) Tri-County Head Start Program. (1988). Durango, CO. Unpublished material.

MENTAL HEALTH CENTER QUESTIONNAIRE ON SERVICES PROVIDED

SAMPLE

1. What is the geographical area served by your mental health center?

2. List the other principal treatment resources for child mental health in the geographical area you serve.

3. What services does your center provide children? Please check the following:

	As a separate service within the center itself	As part of the general services of the center itself	Outside the center through affiliation agreement
Out-patient service	_____	_____	_____
In-patient service	_____	_____	_____
Emergency service	_____	_____	_____
Partial hospitalization service	_____	_____	_____
Consultation and education service	_____	_____	_____

4. Which services that you provide children are available to Head Start children through existing funding at no additional cost?

5. What are the specific services which are included in your agreement with the Head Start program(s) in your geographical area?

Source: Hawks, D. (1978). *The mental health consultant for Head Start* (2nd ed.). College Park, MD: University of Maryland College Center for Professional Development.

MENTAL HEALTH CENTER QUESTIONNAIRE ON SERVICES PROVIDED SAMPLE - PAGE 2

6. Name each of the Head Start centers which are in your service area and check those to which you provide a mental health consultant or consultation service.

7. Name the mental health consultant.

8. How often do you provide consultation to each center?

9. With which Head Start centers do you feel you have good communication?

10. With which Head Start centers do you feel communication should be improved?

11. Within a year about how often does each Head Start center contact you for assistance with a child?

12. Which Head Start centers have requested services but services could not be provided.

13. Within a year how often do you meet with Head Start parent groups for orientation to the objectives of the Head Start mental health program or the services of your center?

14. List names and areas of expertise of professionals on your staff who specialize in dealing with the mental health problems of preschool children (i.e., psychiatrist, psychologist, R.N., M.S.W.).

Source: Hawks, D. (1978). *The mental health consultant for Head Start* (2nd ed.). College Park, MD: University of Maryland College Center for Professional Development.

STRATEGY SHEET FOR IMPLEMENTING A PREVENTIVE MENTAL HEALTH PROGRAM

HOW CAN I (WE) DEVELOP A PREVENTIVE HEALTH APPROACH WITH:	WHAT RESOURCES CAN (WE) USE?	WHAT TOPICS SHOULD MENTAL HEALTH ADDRESS CONCERNING CHILDREN AND ADULTS?
PARENTS	HEAD START RESOURCE CENTER	PARENTS
CHILDREN	COMMUNITY (PRIVATE AND PUBLIC)	CHILDREN
STAFF		STAFF
OTHERS	STATE AND LOCAL GOVERNMENT	OTHERS

Source: Hawks, D. (1978). *The mental health consultant for Head Start* (2nd ed.). College Park, MD: University of Maryland College Center for Professional Development.

STRATEGY SHEET FOR IMPLEMENTING A PREVENTIVE MENTAL HEALTH PROGRAM

SAMPLE

HEAD START MENTAL HEALTH PLAN: ACTIVITIES FOR PARENTS

PROBLEM: Parents: Twenty-five percent of the parents refused to sign permission slips to have their children observed by the mental health professional when deemed necessary.

GOAL/ PERFORMANCE STANDARD	ACTIVITY	RESPONSIBILITY 1=Lead 2=Assist	TIME LINE (Jan - Dec)	DOCUMENTATION	EVALUATION
Goal: That 100% of parents will sign the permission slips to have their child observed by the mental health professional. Performance Standard: 1304.3-8(b)-(6)	In the parent orientation, have the mental health professional explain the observation process.	PIC = 1 MHC = 2	August - January	Orientation agenda. Parent sign-in sheet for orientation.	Parent evaluation form on meeting. Number of parents signing mental health consulation slips.
	At the parent meeting, use other available media to discuss mental health (videos, literature).	MHC = 1 PIC = 2	August - May	Parent sign-in sheets for meeting. Agenda for meeting.	Parent evaluation form on meeting. Number of parents signing mental health consulation slips.
	If parents do not want to sign permission slips, the MHC and/or MHP will talk with them individually.	MHC = 1 PIC = 2	August - May	Report on visits to family.	Number of parents who give permission.

PIC = Parent Involvement Coordinator

MHC = Mental Health Coordinator

HEAD START MENTAL HEALTH PLAN: ACTIVITIES FOR STAFF

PROBLEM: Staff: Thirty percent of the staff feel isolated and frustrated with the families they serve.

GOAL/ PERFORMANCE STANDARD	ACTIVITY	RESPONSIBILITY 1=Lead 2=Assist	TIME LINE (Jan - Dec)	DOCUMENTATION	EVALUATION
Goal: To provide opportunities for staff to discuss issues and problem-solve solutions to specific situations.	Provide a staff support group.	Admin = 1 MHC = 2	Once a Month	Staff sign-in sheets.	At end of year conduct survey to find out if staff feel less isolated.
Performance Standard: N/A (Objective for Staff: To work in a supportive environment)	Design a staff buddy system.	Admin = 1	Begin in August at preservice	A written report on design and implementation of the system.	Staff evaluation of system.
	Plan training on the role of the helper.	MHC = 1 All other Coordin.	September	Training outline/agenda. Staff sign-in sheets.	Staff evaluation of the session. Trainer follow-up to see if techniques have been implemented.

Admin = Administrator

MHC = Mental Health Coordinator

MENTAL HEALTH PLAN: ACTIVITIES FOR STAFF SAMPLE

HEAD START MENTAL HEALTH PLAN: ACTIVITIES FOR CHILDREN

PROBLEM: Children: Parents have indicated problem behaviors in their children that you recognize as stress-related symptoms. While these symptoms are a direct result of recent neighborhood tensions which cannot be resolved overnight, you feel that teaching the children some relaxation techniques will help modify this behavior. The parents are relieved that the children can learn something to help themselves handle tension.

GOAL/ PERFORMANCE STANDARD	ACTIVITY	RESPONSIBILITY 1=Lead 2=Assist	TIME LINE (Jan - Dec)	DOCUMENTATION	EVALUATION
Goal: Children will learn to reduce tension through yoga relaxation techniques.	Identify and contract with a yoga instructor to teach staff the techniques of yoga.	MHC=1 HC =2	April - July	Contract.	Evaluation of instructor. Instructor evaluation of staff and coordination.
Performance Standards: 1304.3-8(b)(8) and 1304.3-8(a)(2)	Provide supervision of technique, support, and general assistance.	MHC=1 Yoga Teacher=1 HC =2 EC =2	October - November	Classroom observation reports written by yoga teacher.	Teacher evaluation of instructor supervision. Instructor evaluation of teacher's technique.
	Begin providing yoga instruction in the classroom for 15 minutes at the same time each day.	MHC=1 EC =1 Yoga Teacher=2 Ed Staff=2	December: Weeks 1 & 2	Pretest screening for children 's stress. Post-screening at end of year.	Education Supervisor evaluation of yoga program. Teacher evaluation of yoga program. Parent evaluation of yoga program.

MHC = Mental Health Coordinator

HC = Health Coordinator

EC = Education Coordinator

Ed Staff = Education Staff

HEAD START MENTAL HEALTH PLAN

PROBLEM:

GOAL/ PERFORMANCE STANDARD	ACTIVITY	RESPONSIBILITY 1=Lead 2=Assist	TIME LINE (Jan - Dec)	DOCUMENTATION	EVALUATION

Goal:

Performance Standard:

SITUATION PRACTICE SHEET
SAMPLE

WHAT DO I DO NOW?

Here are some "What do I do now?" examples. Read each of the situations and list three action steps you could take if this were to happen in your program. If they are situations that have occurred, think back to what action you took and what you might do if the situation were to happen again.

PROBLEM	ACTIONS
Several non-English speaking families move into your community mid-year and are placed in the Head Start program. Staff has no experience with their culture.	1. 2. 3.
A staff member is killed in one of your centers.	1. 2. 3.
The Director leaves mid-year.	1. 2. 3.

Source: Martner, J. (1989). Washington, DC: Georgetown University Head Start Mental Health Project. Unpublished material.

SITUATION PRACTICE SHEET
SAMPLE - PAGE 2

PROBLEM	ACTIONS
The mental health professional you have hired is not providing the type of assistance and input to teachers that you would like.	1. 2. 3.
One of the children in the program is HIV positive.	1. 2. 3.
A major employer of the families in your program shuts down.	1. 2. 3.

Source: Martner, J. (1989). Washington, DC: Georgetown University Head Start Mental Health Project. Unpublished material.

PROGRAM ASSESSMENT FOR THE MENTAL HEALTH COMPONENT

SAMPLE

ITEM	YES	NO	DOCUMENTATION	COMMENTS
1. Is there a written plan that has been developed with the advice and concurrence of parents, reviewed by the Health Service Advisory Committee, and reviewed and updated by the Policy Council?				
2. Does the program utilize the service of a mental health consultant?				
a. Is there a written agreement with the consultant?				
b. Is the consultant utilized for preventive mental health activities such as observations in the classroom, training on behavior management, positive reinforcement, and good self-concept for parents, children and staff?				
c. Has the program informed the consultant of the difference between the Mental Health and Handicap components?				
d. Is the consultant involved in the development of child assessment tools utilized by the program?				
e. Is the consultant available for working with parents and staff on special problems on an individual basis?				
3. Is there a good mental health attitude and atmosphere in the classroom that contributes to the child's positive self esteem?				
a. Is there a consistency between what the teacher says and how she behaves?				

Source: Riley, M.T. (1984). *Skill building block: Tele-Chek.* Lubbock, TX: Texas Tech University Child and Family Institute.

PROGRAM ASSESSMENT FOR THE MENTAL HEALTH COMPONENT SAMPLE - PAGE 2

ITEM	YES	NO	DOCUMENTATION	COMMENTS
b. Does the teacher encourage children to help each other?				
c. Is there open, easy communication between staff and children?				
d. Does the teacher praise the children's positive actions?				
e. Are limits explained to the children?				
4. Are mental health activities integrated into the lesson plans?				
5. Is parental permission documented before observation and evaluations are done on the children by the mental health consultant?				
6. Are confidentiality procedures followed for mental health evaluations?				
7. Are appropriate tests utilized for age and socio-economic levels?				
8. Are community mental health resources utilized?				
9. Are parents involved in the mental health component?				
a. Do parents receive orientation to the mental health component?				
b. Are there regular group meetings of parents and program staff?				
c. Can parents obtain individual assistance?				

Source: Riley, M.T. (1984). *Skill building block: Tele-Chek.* Lubbock, TX: Texas Tech University Child and Family Institute.

APPENDICES

APPENDIX A

HEAD START MENTAL HEALTH PROGRAM PERFORMANCE STANDARDS

HEALTH

PERFORMANCE STANDARDS	GUIDANCE
(4) Health education is integrated into ongoing classroom and other program activities.	(4) The most important health education activity of a program is the example it sets by providing each child with pleasant, dignified, individualized care within the health program. Parents learn from the emphasis placed on careful examinations, immunizations, dental care, and other health measures that such health activities are important for their children. Parents' participation in classroom activities and in the health care process related to the child (screening, examinations) can be an effective method of health education for the entire family. Teachers should integrate health into the curriculum and daily activities of the children.
(5) The children are familiarized with all health services they will receive prior to the delivery of those services.	(5) Health education can build on the health services program in another way. Each screening test, immunization, and examination can be discussed in the classroom. This will serve both to prepare the children for an unusual experience and to give them a new knowledge about how each of these measures can contribute to their health. Children love to act out the experiences they have had with the doctor or nurse.
§ 1304.3-7 Mental health objectives. The objectives of the mental health part of the health services component of the Head Start program are to:	These are the outcomes toward which the program efforts should be directed.
(a) Assist all children participating in the program in emotional, cognitive and social development toward the overall goal of social competence in coordination with the education program and other related component activities;	
(b) Provide handicapped children and children with special needs with the necessary mental health services which will ensure that the child and family achieve the full benefits of participation in the program;	
(c) Provide staff and parents with an understanding of child growth and development, an appreciation of individual differences, and the need for a supportive environment;	
(d) Provide for prevention, early identification and early intervention in problems that interfere with a child's development;	
(e) Develop a positive attitude toward mental health services and a recognition of the contribution of psychology, medicine, social services, education and other disciplines to the mental health program; and	

Source: Office of Human Development Services. (1984). Head Start program performance standards (DHHS Publication No. [OHDS] 84-31131). Washington, DC: U.S. Government Printing Office.

HEALTH

PERFORMANCE STANDARDS	GUIDANCE
(f) Mobilize community resources to serve children with problems that prevent them from coping with their environment.	
§ 1304.3-8 Mental health services.	
(a) The mental health part of the plan shall provide that a mental health professional shall be available, at least on a consultation basis, to the Head Start program and to the children. The mental health professional shall:	(a) A mental health professional is a child psychiatrist, a licensed psychologist, or a psychiatric nurse or psychiatric social worker. Both the psychiatric nurse and psychiatric social worker should have experience in working with young children. A mental health aide may be a member of the mental health team provided the aide is under the supervision of one of the above professionals. A mental health professional may be secured from a mental health center in the geographical areas, the school system, a university, or other appropriate vendors capable of providing comprehensive mental health services.
(1) Assist in planning mental health program activities;	(1) The mental health professional should meet with the Head Start Director, the coordinator responsible for mental health services, and representative parents to assist in developing a plan for delivery of mental health services. The planning should focus on the setting of priorities according to program needs and availability of trained personnel and resources. Mental health program activities include: • pre-service and in-service training of teachers and aides; • consultation with teachers and teachers' aides; • work with parents; • screening, evaluation, and recommendations for intervention for children with special needs. The mental health professional should meet annually with appropriate staff and parents to assist in evaluation of objectives of the plan and to assist in revision of objectives for the following year.
(2) Train Head Start staff;	(2) Be involved in the assessment of mental health training needs, in designing the mental health training program, in the selection of trainers, and evaluating staff members' progress Provide information which will help staff members better understand normal development as well as the more common behavior problems seen in children. Training should include observation techniques and methods in meeting the assessed needs of the child.
(3) Periodically observe children and consult with teachers and other staff;	(3) The mental health professional can provide practical advice and help to the teaching staff by

Source: Office of Human Development Services. (1984). Head Start program performance standards (DHHS Publication No. [OHDS] 84-31131). Washington, DC: U.S. Government Printing Office.

PERFORMANCE STANDARDS	GUIDANCE
	observing the children in their physical surroundings at least semi-annually. Teachers can share their information, ideas, and suggestions about the children.
(4) Advise and assist in developmental screening and assessment;	(4) Advise and assist staff in devising a process for screening children with atypical behavior, and in evaluating children needing further assessment. In addition, the mental health professional will train or assist in obtaining training for teachers in use of behavior checklists and other screening instruments. Classroom observation and screening should be initiated within the early weeks of class attendance and then continued on a periodic basis – as considered necessary by staff and/or mental health professional. Included in screening and evaluation are: • Physical coordination and development; • Intellectual development; • Sensory development with special emphasis on sensory discrimination; • Emotional development; • Social development.
(5) Assist in providing special help for children with atypical behavior or development, including speech;	(5) Advise and assist in provision of special services for children with atypical behavior or development, including language and speech. Through staff conferences, practical recommendations may be generated when working with the child with special needs. For example, the use of games aimed at increasing the child's verbal expression, how the staff may work with the overly shy or overly aggressive child, and how to curb impulsive behavior.
(6) Advise in the utilization of other community resources and referrals;	(6) The mental health professional should have a working knowledge of mental health resources in the community in order to assist in development of a file of community resources, including referral procedures and documentation of their use. Examples of such resource agencies include child guidance clinics, community mental health centers, psycho-educational clinics, and State or county children's services.
(7) Orient parents and work with them to achieve the objectives of the mental health program; and	(7) Orient parents and work with them to achieve the objectives of the mental health program, including advising parents on how to secure assistance on individual problems, assisting center staff in developing an ongoing education in mental health for parents, and evaluating the effectiveness of the parent mental health education program.

Source: Office of Human Development Services. (1984). Head Start program performance standards (DHHS Publication No. [OHDS] 84-31131). Washington, DC: U.S. Government Printing Office.

HEALTH

PERFORMANCE STANDARDS	GUIDANCE
	The mental health professional should help parents to recognize a variety of ways in which they can further their children's intellectual, emotional, and social development at home. This may be accomplished through individual or group meetings.
(8) Take appropriate steps in conjunction with health and education services to refer children for diagnostic examination to confirm that their emotional or behavior problems do not have a physical basis.	(8) When a child is referred for emotional or behavioral problems, a physical examination should be included in the assessment in order to rule out a physical cause for the mental health problem which can be treated.
(b) The plan shall also provide	
(1) attention to pertinent medical and family history of each child so that mental health services can be made readily available when needed;	(1) The assessment of each child's medical records, family history and home visits by appropriate coordinators and teachers, for information, will indicate if the child or his family may need additional assistance from the mental health program. A plan for follow-through will be written for each child whose medical and/or family history and/or home visit suggests a potential for emotional or behavioral problems. The plan should include objectives to be evaluated monthly.
(2) use of existing community mental health resources;	(2) Procedures for utilizing existing community mental health resources including specified contact persons. These procedures should be developed in conjunction with the mental health professional for identifying and contacting resources.
(3) coordination with the education services component to provide a program keyed to individual developmental levels;	(3) The mental health professional and the educational coordinator should work closely with each teacher and the parents in designing an education program for each child based on his developmental level and in training teachers to be able to do such program planning. Conferences should be held periodically with the staff to discuss particular children who have been identified as needing special help. The mental health professional should share ideas and suggestions with staff on helping the child benefit from the program.
(4) confidentiality of records;	(4) Only authorized persons should be permitted to see the records. Parents and staff should jointly decide if such records are forwarded to the school system.
(5) regular group meetings of parents and program staff;	(5) Periodic group meetings at least quarterly, between parents and staff can be used for identifying and discussing child development, discipline, childhood fears, complex family problems, and other parental and staff concerns. A mental health professional should be present at these sessions periodically.

Source: Office of Human Development Services. (1984). Head Start program performance standards (DHHS Publication No. [OHDS] 84-31131). Washington, DC: U.S. Government Printing Office.

HEALTH

PERFORMANCE STANDARDS	GUIDANCE
(6) parental consent for special mental health services;	(6) There must be a written consent from the parent for special mental health service. A standard "informed consent" form should be used and should include the following: the name of the child, the name of the service provider, a description of the services to be provided, and the date the form was signed.
(7) opportunity for parents to obtain individual assistance; and,	(7) Opportunities should be provided for parents to discuss individual problems of the child or the family with the mental health professional. This can be done on an appointment basis.
(8) active involvement of parents in planning and implementing the individual mental health needs of their children.	(8) There should be a parent orientation meeting to explain the mental health program and the available services. Ideally, the mental health professional should conduct this meeting. Parents should be involved in developing and evaluating the mental health program.

Source: Office of Human Development Services. (1984). Head Start program performance standards (DHHS Publication No. [OHDS] 84-31131). Washington, DC: U.S. Government Printing Office.

APPENDIX B

OTHER HEAD START COMPONENT PROGRAM PERFORMANCE STANDARDS RELATED TO MENTAL HEALTH

PROGRAM PERFORMANCE STANDARDS RELATED TO MENTAL HEALTH

The following Head Start Performance Standards are taken from the Education, Health, Social Services, and Parent Involvement components. Each standard relates to mental health and the coordinators for each component should work together to meet the standard.

EDUCATION

Subpart B -- Education Services Objectives and Performance Standards

PERFORMANCE STANDARDS	GUIDANCE
§1304.2-1 Education services objectives.	
The objectives of the Education Service component of the Head Start program are to:	
(a) Provide the children with a learning environment and the varied experiences which will help them develop socially, intellectually, physically, and emotionally in a manner appropriate to their age and stage of development toward the overall goal of social competence.	
(b) Integrate the educational aspects of the various Head Start components in the daily program of activities.	
(c) Involve parents in educational activities of the program to enhance their role as the principal influence on the child's education and development.	
(d) Assist parents to increase knowledge, understanding, skills, and experience in child growth and development.	
(e) Identify and reinforce experiences which occur in the home that parents can utilize as educational activities for their children.	

Source: (Compiled by) Office of Community Program Operations and the Children's Bureau. (1989). Kansas City, MO. Unpublished material.

PERFORMANCE STANDARDS

§1304.2-2 Education services plan content: operations.

(a) The education services component of the performance standards plan shall provide strategies for achieving the education objectives. In so doing it shall provide for program activities that include an organized series of experiences designed to meet the individual differences and needs of participating children, the special needs of handicapped children, the needs of specific educational priorities of the local population and the community. Program activities must be carried out in a manner to avoid sex role stereotyping. In addition, the plan shall provide methods for assisting parents in understanding and using alternative ways to foster learning and development of their children.

(b) The education services component of the plan shall provide for:

(1) A supportive social and emotional climate which:

(i) Enhances children's understanding of themselves as individuals, and in relation to others, by providing for individual, small group, and large group activities;

GUIDANCE

(1) The following suggestions may be useful beginning steps:

(i) Encourage awareness of self through the use of full-length mirrors, photos and drawings of child and family, tape recordings of voices, etc.

- Use child's name on his/her work and belongings.
- Arrange activity settings to invite group participation (block and doll corners, dramatic play).
- Include active and quiet periods, child-initiated and adult-initiated activities, and use of special areas for quiet and individual play or rest.

Source: (Compiled by) Office of Community Program Operations and the Children's Bureau. (1989). Kansas City, MO. Unpublished material.

PERFORMANCE STANDARDS	GUIDANCE
(ii) Gives children many opportunities for success through program activities;	(ii) Here are some examples: • Make sure that activities are suited to the developmental level of each child; • Allow the child to do as much for himself as he can; • Help the child learn "self help" skills (pouring milk, putting on coat); • Recognize and praise honest effort and not just results; • Support efforts and intervene when helpful to the child; • Help the child accept failure without defeat ("I will help you try again"); • Help the child learn to wait ("You will have a turn in five minutes"); • Break tasks down into manageable parts so that children can see how much progress they are making.
(iii) Provides an environment of acceptance which helps each child build ethnic pride, develop a positive self-concept, enhance his individual strengths, and develop facility in social relationships.	(iii) This can be accomplished by adult behavior such as: • Showing respect for each child; • Listening and responding to children; • Showing affection and personal regard (greeting by name, one-to-one contact); • Giving attention to what the child considers important (looking at a block structure, locating a lost mitten); • Expressing appreciation, recognizing effort and accomplishments of each child, following through on promises;

Source: (Compiled by) Office of Community Program Operations and the Children's Bureau. (1989). Kansas City, MO. Unpublished material.

PERFORMANCE STANDARDS	GUIDANCE
	• Respecting and protecting individual rights and personal belongings (a "cubby" or box for storage, name printed on work in large, clear letters);
	• Acknowledging and accepting unique qualities of each child;
	• Avoiding situations which stereotype sex roles or racial/ethnic backgrounds;
	• Providing ample opportunity for each child to experience success, to earn praise, to develop an "I can," "Let me try," attitude;
	• Accepting each child's language, whether it be standard English, a dialect or a foreign language; fostering the child's comfort in using the primary language;
	• Providing opportunities to talk about feelings, to share responsibilities, to share humor.
(c) The education services component of the plan shall provide for a program which is individualized to meet the special needs of children from various populations by:	
(1) Having a curriculum which is relevant and reflective of the needs of the population served (bilingual/bicultural, multicultural, rural, urban, reservation, migrant, etc.).	(1) This can be accomplished by including in each classroom materials and activities which reflect the cultural background of the children. Examples of materials include: • books • records • posters, maps, charts • dolls, clothing Activities may include: • Celebration of cultural events and holidays; • Serving foods related to other cultures; • Stories, music, and games representative of children's background; • Inviting persons who speak the child's native language to assist with activities.

Source: (Compiled by) Office of Community Program Operations and the Children's Bureau. (1989). Kansas City, MO. Unpublished material.

PERFORMANCE STANDARDS	GUIDANCE
(2) Having staff and program resources reflective of the racial and ethnic population of children in the program.	
(i) Including persons who speak the primary language of the children and are knowledgeable about their heritage; and, at a minimum, when the majority of the children speak a language other than English, at least one teacher or aide interacting regularly with the children must speak their language; and	(i) This adult may be: • a teacher or aide; • other member of the center staff; • a parent or family member; • a volunteer who speaks the child's language.
(ii) Where only a few children, or a single child, speak a language different from the rest, one adult in the center should be available to communicate in the native language.	(ii) In some cases where a single child is affected it may not be possible for the center to provide an adult speaking the child's language on a regular basis.
(3) Including parents in curriculum development and having them serve as resource persons (e.g., for bilingual/bicultural activities).	(3) Parents can be valuable resources in planning activities which reflect the children's heritage. Teachers may request suggestions from parents on ways to integrate cultural activities into the program.
(d) The education services component of the plan shall provide procedures for on-going observation, recording and evaluation of each child's growth and development for the purpose of planning activities to suit individual needs. It shall provide also for integrating the educational aspects of other Head Start components into the daily education services program.	(d) The education plan should specify how Head Start staff will assess the individual developmental/instructional needs of children. Some ways this may be accomplished include: • Discussions with parent during recruitment, enrollment, home visits, parent-staff conferences and meetings; • Review of child's medical and developmental records; • Conference with medical or psychological consultants where indicated; • Teacher observation documenting developmental progress used as guidance in planning for and/or modifying individual children's activities; • Use of specific assessment instruments or scales.

Source: (Compiled by) Office of Community Program Operations and the Children's Bureau. (1989). Kansas City, MO. Unpublished material.

PERFORMANCE STANDARDS	GUIDANCE
(e) The plan shall provide methods for enhancing the knowledge and understanding of both staff and parents of the educational and developmental needs and activities of children in the program. These shall include:	(e) The plan should indicate some of the ways parents and staff will work together to understand each child and provide for his learning experiences. The plan should include details of ways the home and center will attempt to supplement each other in providing positive experiences for the child. There should be an early orientation to the Education Services Objectives. Special emphasis should be given to the significance of the materials, equipment and experiences provided in a Head Start Child Development program. Interpreters should be available to facilitate full participation of non-English speaking parents. Procedures should be established to facilitate maximum communication between staff and parents, for example: • newsletters • parent/teacher conferences • group meetings • phone calls • home visits • posters, bulletin boards, radio/TV announcements
(1) Parent participation in planning the education program, and in center, classroom and home program activities;	(1) Meeting with staff to provide for the overall written education plan (see item §1304.2-2(a) for further guidance).
(2) Parent training in activities that can be used in the home to reinforce the learning and development of their children in the center;	(2) Some examples are: • orientation and training sessions • designing activities for children at home • participation in classroom activities
(3) Parent training in the observation of growth and development of their children in the home environment and identification of and handling special developmental needs;	(3) Provide parents with films, workshops, publications, specialists, professionals, etc., in child growth and development. Arrange for films, publications and specialists to provide training.
(4) Participation in staff and staff-parent conferences and the making of periodic home visits (no less than two) by members of the education staff;	(4) Areas of mutual concern to be discussed could include: • child's developmental progress; • child rearing issues; • discussion of possible home activities to expand the Head Start experience; • discussion of health problems or handicapping conditions of the Head Start child.

Source: (Compiled by) Office of Community Program Operations and the Children's Bureau. (1989). Kansas City, MO. Unpublished material.

PERFORMANCE STANDARDS	GUIDANCE
(5) Staff and parent training, under a program jointly developed with all components of the Head Start program, in child development and behavioral developmental problems of preschool children; and	(5) An orientation and training program should be planned in cooperation with other component staff members and parents. The training program should provide for periodic formal and informal sessions. The content, organization, staffing and scheduling will depend on the individual program needs as determined in the planning stage. Training should focus on the normal child as well as the child with special needs. Emphasis should be on mental, physical, social, and emotional growth and development.
(6) Staff training in identification of handling children with special needs and working with the parents of such children, and in coordinating relevant referral resources.	(6) Training should also familiarize staff and parents with appropriate referral resources in the community. (Refer to §1304.3-3(b)(10)).

HEALTH

Subpart C -- Health Services Objectives and Performance Standards

§1304.3-1 Health Services general objectives.

The general objectives of the health services component of the Head Start program are to:

(a) Provide a comprehensive health services program which includes a broad range of medical, dental, mental health and nutrition services to preschool children, including handicapped children, to assist the child's physical, emotional, cognitive, and social development toward the overall goal of social competence.	(a), (b), & (c) these are the aims toward which the program efforts should be directed.
(b) Promote preventive health services and early intervention.	
(c) Provide the child's family with the necessary skills and insight and otherwise attempt to link the family to an ongoing health care system to ensure that the child continues to receive comprehensive health care even after leaving the Head Start program.	

Source: (Compiled by) Office of Community Program Operations and the Children's Bureau. (1989). Kansas City, MO. Unpublished material.

PERFORMANCE STANDARDS	GUIDANCE
§1304.3-6 Health education.	
(a) The plan shall provide for an organized health education program for program staff, parents and children which ensures that:	(a) Health personnel should devote a substantial amount of time in helping the Head Start staff and parents understand the implications of health findings for individual children, and for the program in general. Regularly scheduled consultations between the physician and the teachers are suggested for this purpose.
(1) Parents are provided with information about all available health resources;	(1) A local health resource booklet or pamphlet should be prepared for distribution to parents. The information ought to be categorized by services.
(2) Parents are encouraged to become involved in the health care process relating to their child. One or both parents should be encouraged to accompany their child to medical and dental exams and appointments;	(2) Parents can learn about health as a continuing process and not just as a physical and dental examination if they accompany the child to the examination.
§1304.3-9 Nutrition objectives.	
The objectives of the nutrition part of the health services component of the Head Start program are to:	
(a) Help provide food which will help meet the child's daily nutritional needs in the child's home or in another clean and pleasant environment, recognizing individual differences and cultural patterns, and thereby promote sound physical, social, and emotional growth and development.	
(b) Provide an environment for nutritional services which will support and promote the use of the feeding situation as an opportunity for learning;	
(d) Demonstrate the interrelationships of nutrition to the other activities of the Head Start program and its contribution to the overall child development goals; and	

Source: (Compiled by) Office of Community Program Operations and the Children's Bureau. (1989). Kansas City, MO. Unpublished material.

PERFORMANCE STANDARDS	GUIDANCE
§1304.3-10 Nutrition services.	
(a) The nutrition services part of the health services component of the performance standards plan must identify the nutritional needs and problems of the children in the Head Start program and their families. In so doing account must be taken of:	
(2) Information about family eating habits and special dietary needs and feeding problems, especially handicapped children; and	(2) This information should be obtained by talking with parents early in the year. The interviewer should receive orientation and training on how to conduct such interviews for a nutritionist. The information will be used to assure that many good aspects of the family eating patterns are reinforced through food served in the center; that special dietary needs are met at the center; and that this information will be considered in developing a nutrition plan with families.
(c) The plan shall undertake to ensure that the nutrition services contribute to the development and specialization of the children by providing that:	(c) Mealtimes should promote the physical, social and emotional development of children. This needs to take place in a quiet, well-lighted and ventilated area.
(2) Food is not used as a punishment or reward, and that children are encouraged but not forced to eat or taste;	(2) If a child refuses a food, offer it again at some future time, don't keep pestering the child. Forcing children to eat or using desserts or other foods as reward or punishment may create problem eaters and unpleasant or undesirable associations with food. Remember that all foods offered should contribute to the child's needs, including the dessert. "Clean plate" clubs, stars and other gimmicks to encourage children to eat are not appropriate.
(4) Sufficient time is allowed for children to eat;	(4) Serve children as soon as they come to the table. Slow eaters should be allowed sufficient time to finish their food (about 30 minutes). If children become restless before the meal period is over allow them to get up and move around, i.e., the children can take their plate to a cleaning area away from the table when finished. A leisurely meal time pace should be encouraged.

Source: (Compiled by) Office of Community Program Operations and the Children's Bureau. (1989). Kansas City, MO. Unpublished material.

PERFORMANCE STANDARDS	GUIDANCE
	Some handicapped children may be eating at a different developmental level than the other children. For example, if the 3-year-old child is eating with skills of a 2-year-old, start where the child is and plan with a nutritionist or other therapist for helping the child reach an adequate level of self-feeding skill.

SOCIAL SERVICES

Subpart D -- Social Services Objectives and Performance Standards

§1304.4-1 Social services objectives.

The objectives of the social services component of the performance standards plan are to:

(b) Provide enrollment of eligible children regardless of race, sex, creed, color, national origin, or handicapping condition.

(d) Assist the family in its own efforts to improve the condition and quality of family life.

§1304.4-2 Social services plan content.

(a) The social service plan shall provide procedures for:

(a) Input into the plan should be made by staff and parents.

(3) Providing or referral for appropriate counseling.

(4) Emergency assistance or crisis intervention;

(3) (4) Preferably, these services should be available directly from the Head Start program. If unavailable directly, provisions should be made for obtaining appropriate services from outside resources.

(5) Furnishing information about available community services and how to use them;

(5) The procedure should ensure that all available community resources are used to the maximum extent possible.

(6) Follow-up to assure delivery of needed assistance;

(6) Agencies to whom children or other family members were referred should be contacted to assure the services were satisfactorily provided.

Source: (Compiled by) Office of Community Program Operations and the Children's Bureau. (1989). Kansas City, MO. Unpublished material.

PERFORMANCE STANDARDS	GUIDANCE
(8) Contacting of parent or guardian with respect to an enrolled child whose participation in the Head Start program is irregular or who has been absent four consecutive days; and	(8) Social services staff should make regularly scheduled family contacts (preferably home visits) and should assess and re-assess family needs on a continuing basis. These contacts should be coordinated with other component staff.
(b) The plan shall provide for close cooperation with existing community resources including,	
(2) Communicating to other community agencies the needs of Head Start families, and ways of meeting these needs;	
(3) Helping to assure better coordination, cooperation and information sharing with community agencies;	(3) Ways of facilitating communication with other social service providers in the community include visiting those providers, inviting those providers to visit the Head Start program, placing providers on a special Head Start mailing list to receive pertinent information, being placed on providers' mailing list to keep abreast of the providers' activities, and developing a media relations program with local press, radio stations, and TV stations.
(5) Preparing and making available a community resource list to Head Start staff and families.	(5) In communities where another agency prepares a community resource list, the Head Start program might update the list and make it more relevant for Head Start purposes.

PARENT INVOLVEMENT

Subpart E -- Parent Involvement Objectives and Performance Standards

§1384.5-1 Parent involvement objectives.

The objectives of the parent involvement component of the performance standards are to:

(a) Provide a planned program of experiences and activities which support and enhance the parental role as the principal influence in their child's education and development.

Source: (Compiled by) Office of Community Program Operations and the Children's Bureau. (1989). Kansas City, MO. Unpublished material.

PERFORMANCE STANDARDS	GUIDANCE
(b) Provide a program that recognizes the parent as:	
(1) Responsible guardians of their children's well being.	
(2) Prime educators of their children.	
(3) Contributors to the Head Start program and their communities.	
§1304.5-3 Parent involvement plan content: enhancing development of parenting skills.	
The plan shall provide methods and opportunities for involving parents in:	
(a) Experiences and activities which lead to enhancing the development of their skills, self confidence, and sense of independence in fostering an environment in which their own children can develop to their full potential.	(a) Parents should be encouraged to participate in Head Start policy groups and on community boards of directors and committees. Parents should be given the opportunity and encouraged to conduct sessions for staff, children, and other parents in relevant activities for which they have special skills. Parents should be encouraged to participate as volunteers in social service activities making contact with community social agencies and making home visits as well as volunteering in the classrooms.
(b) Experiences and child growth and development which will strengthen their role as the primary individual in their children's lives.	(b) Parents should be provided with guidance, information and training in the enhancement of their parenting skills, personal development, and child development concepts through such means as films, brochures, discussion groups, rap sessions, courses, books and parent-child interaction activities in the home and center. As excellent resources for accomplishing these goals would be the use of the twenty ession Exploring Parenting curriculum, a parent education curriculum developed by the Head Start Bureau/ACYF in 1976 for use with Head Start parents.

Source: (Compiled by) Office of Community Program Operations and the Children's Bureau. (1989). Kansas City, MO. Unpublished material.

PERFORMANCE STANDARDS	GUIDANCE
(c) Ways of providing educational and developmental activities for children in the home and community.	(c) Parents could be exposed to specific activities which foster learning in children in the home, e.g., the use of common household items to teach the names of colors, as in "Bring me the blue towel," and in the community, e.g., planning a trip to the store.
(d) Health, mental health, dental and nutritional education.	(d) Training could be made available to parents either in conjunction with staff training in these areas or as a unit by itself.
(e) Identification, and use, of family and community resources to meet the basic life support needs of the family.	(e) Parents should be provided or made aware of available community resources, such as adult classes in consumer education, financial assistance programs, and family and employment counseling. This ought to be coordinated with the social services component to avoid duplication of effort and to strengthen the family-centered approach of Head Start.
§1304.5-4 Parent involvement plan content: communication among program management, program staff, and parents.	
(a) The plan shall provide for two-way communication between staff and parents carried out on a regular basis throughout the program year which provides information about the program and its services; program activities for the children; the policy groups; and resources within the program and the community. Communications must be designed and carried out in a way which reaches parents and staff effectively. Policy groups, staff and parents must participate in the planning and development of the communication system used.	(a) Examples of specific communication techniques include newsletters, home visits, training sessions, and policy group meetings. These techniques should be programmed to occur on a regular and continuous basis -- e.g., *monthly* newsletter, and *bimonthly* group meetings.

Source: (Compiled by) Office of Community Program Operations and the Children's Bureau. (1989). Kansas City, MO. Unpublished material.

APPENDIX C

REFERENCE BIBLIOGRAPHY

These references are for your reading for more in-depth information and supplement material in this manual. They are divided into the areas of Prevention, Identification/Referral, Treatment and Books for Children. Many of the books listed in the first three categories may also fit in other categories since the information they contain may overlap into other categories.

PREVENTION

Curriculum/Teaching Strategies

Borba, M., & Borba, C. (1974). *Self esteem: A classroom affair (101 ways to help children like themselves).* Minneapolis, MN: Winston Press.

Canfield, J., & Wells, H.C. (1976). *100 ways to enhance self-concept in the classroom.* Englewood Cliffs, NJ: Prentice-Hall.

Creative Associates, Inc. (1979). *The creative curriculum for early childhood.* Washington, DC: Author.

Davis, D. (1977). *My friends & me.* Circle Pines, MN: American Guidance Service, Inc.

D'Evelyn, K. (1974). *Developing mentally healthy children.* Washington, DC: American Association of Elementary, Kindergarten and Nursery Educators.

Dinkmeyer, D. (1973) *Developing understanding of self and others.* Circle Pines, MN: American Guidance Service, Inc.

Dinkmeyer, D., & Losoncy, L.E. (1980). *The encouragement book.* Englewood Cliffs, NJ: Prentice-Hall.

Dodge, D.T. (1977). *Room arrangement as a teaching strategy.* Washington, DC: Teaching Strategies, Inc.

The faces of many children. (1973). Chicago, IL: Developmental Learning Materials.

Fassler, J. (1978). *Helping children cope: Mastering stress through books and stories.* New York: MacMillan.

Felker, D.W. (1973). *Helping children to like themselves.* Minneapolis, MN: Burgess.

Growing up strong. (1984). Oklahoma City, OK: Oklahoma State Department of Mental Health, Prevention Section.

Harms, R., & James, D. (1983). *Talking about touching.* Seattle, WA: Institute for Child Advocacy.

Hearne, B. (1981). *Choosing books for children: A common sense guide.* New York: Delacorte Press.

Heekin, S. (1983). *New friends: Mainstreaming activities to help young children understand and accept individual differences.* Chapel Hill, NC: Chapel Hill Training-Outreach Project.

An invitation to play: Teacher's guide. (1986). Madison, WI: Wisconsin Department of Public Instruction.

Karnes, M.B. (1983). *Know me, know you.* Allen, TX: Developmental Learning Materials.

Karnes, M.B., Johnson, L.J., & Cohen, T.S. (1986). *Ties.* Champaign, IL: University of Illinois at Urbana/Champaign.

Kobak, D. (1979, March/April). Teaching young children to care. *Children Today,* pp. 16-18.

Kritcheusky, S., & Prescott, E. (1969). *Planning environments for young children.* Washington, DC: National Association for the Education of Young Children.

McCracken, J.B. (Ed.). (1980). *Reducing stress in young children's lives.* Washington, DC: National Association for the Education of Young Children.

McMullan, K.H. (1984). *How to choose good books for children.* Reading, MA: Addison-Wesley.

Office of Human Development Services. (1988). *As I am* (DHHS Publication No. [OHDS] 88-31542). Washington, DC: U.S. Government Printing Office.

Samuels, S. (1977). *Enhancing self-concept in early childhood.* New York: Human Sciences Press.

Saunders, A., & Remsberg, B. (1984). *Stress-proof child.* New York: Holt, Rinehart & Winston.

Smith, C. (1982). *Promoting the social development of young children.* Palo Alto, CA: Mayfield Publishing.

Super me, super you. (1974). Washington, DC: National Coordinating Council on Drug Education.

Zavitkovsky, D., & Baker, K.R. (1986). *Listen to the children.* Washington, DC: National Association for the Education of Young Children.

Multicultural

American Indian Social Research and Development Associates, Inc. (1980). *The American Indian family: Strengths and stresses.* Isleta, NM: Author.

Atkinson, D., Morton, G., & Sue, D.W. (1983). *Counseling American minorities: A cross-cultural perspective* (2nd ed.). Dubuque, IA: William C. Brown.

Bartz, K.W., & Levine, E.S. (1978). Child-rearing by Black parents: A description and comparison to Anglo and Chicano parents. *Journal of Marriage and the Family. XL*(4), 709-719.

Brownlee, A.T. (1978). *Community, culture and care.* St. Louis, MO: C.V. Mosby Co.

Dana, R.H. (1981). *Human services for cultural minorities.* Baltimore, MD: University Park Press.

Gary, L.E. (1978). *Support systems in Black communities: Implications for mental health services for children and youth.* Washington, DC: Institute for Urban Affairs and Research, Howard University.

Koslow, D.R., & Salett, E.P. (Eds.). (1989). *Crossing cultures in mental health.* Washington, DC: SIETAR International.

Montoya, J.R. (1980). *Cultural and ethnic awareness manual for professionals working with Mexican-American migrant families.* Laredo, TX: Texas Migrant Council, Inc., National Resource Center on Child Abuse and Neglect for Mexican-American Migrants, p. 58.

Padilla, A., et al. (1978). *Hispanic mental health bibliography.* Los Angeles: Spanish-Speaking Mental Health Research Center.

Stanley, S., & Morishima, J. (1982). *The mental health of Asian Americans.* San Francisco: Jossey-Bass.

Willie, C., Cramer, B., & Brown, B. (Eds.). (1973). *Racism and mental health.* Pittsburgh: University of Pittsburgh Press.

Administration

Caldwell, B.M., & Hilliard, A.G. (1985). *What is quality child care?* Washington, DC: National Association for the Education of Young Children.

Head Start Bureau (Producer). (1989). *Mental health in Head Start: It's everybody's business* (Videotape). Washington, DC: Georgetown University Child Development Center.

Hersey, P. (1985). *The situational leader.* New York: Warner Books.

Jorde, P. (1982). *Avoiding burnout: Strategies for managing time, space, and people in early childhood.* Washington, DC: Acropolis Books.

Katz, L. (Ed.). (1977). *Current topics in early childhood education.* Norwood, NJ: Ablex Publishing Co.

Keirsey, D., & Bates, M. (1978). *Please understand me: Character and temperament types.* Del Mar, CA: Prometheus Nemesis.

Klei[illegible]L., Browser, M.A., & Kater, E.W. (1978). *Families first.* York, PA: Individual [illegible]nd Family Development Services.

Meisels, S.J. (1985). *Developmental screening in early childhood: A guide.* Washington, DC: National Association for the Education of Young Children.

Neugebauer, R. (1982, November/December). How to be a people-oriented boss. *Child Care Information Exchange*, pp. 20-24.

Wilson, M. (1981). *Survival skills for managers.* Boulder, CO: Volunteer Management Associates.

Parenting

Arent, R.P. (1984). *Stress and your child.* Englewood Cliffs, NJ: Prentice-Hall.

Bavolek, S.J., & Bavolek, J.D. (1985). *Nurturing program for parents and young children (birth to five years old) family resource handbook.* Eau Claire, WI: Family Development Resources.

Brazelton, T.B. (1974). *Toddlers and parents.* New York: Dell.

Brazelton, T.B. (1984). *To listen to a child.* Reading, MA: Addison-Wesley.

Briggs, D.C. (1970). *Your child's self-esteem.* New York: Doubleday.

Chess, S., Alexander, T., & Birch, H.G. (1985). *Your child is a person.* New York: Penguin Books.

Clemes, H., & Bean, R. (1985). *Self-esteem: The key to your child's well being.* New York: G.P. Putnam.

Elkind, D. (1981). *The hurried child: Growing up too fast too soon.* Reading, MA: Addison-Wesley.

Faber, A., & Mazlish, E. (1982). *How to talk so kids will listen and listen so kids will talk.* New York: Avon Books.

An invitation to play. (1986). Madison, WI: Wisconsin Department of Public Instruction.

Looking at life. (1984). Silver Spring, MD: Research Assessment Management, Inc.

Mitchell, G. (1982). *A very practical guide to discipline with young children.* Boston, MA: Telshare Publishers.

Rogers, F., & Head, B. (1983). *Mister Rogers talks with parents.* New York: Berkley Books.

Salk, L. (1984). *What every child would like his parents to know to help him with the emotional problems of everyday life.* New York: Simon & Schuster.

Schaefer, C.E. (1984). *How to talk to children about really important things.* New York: Harper & Row.

Segal, J., & Segal, Z. (1977). *Growing up smart and happy.* New York: McGraw-Hill.

Philosophy

Gordon, T., & Burch, N. (1974). *Teacher effectiveness training.* New York: David McKay Co.

Honig, A.S. (1975). *Parent involvement in early childhood education.* Washington, DC: National Association for the Education of Young Children.

Katz, L. (1979). *Helping others learn to teach.* Urbana, IL: ERIC Clearinghouse on Early Childhood Education.

Pearce, J.C. (1977). *Magical child.* New York: Dutton.

Pearce, J.C. (1985). *Magical child matures.* New York: Dutton.

Rogers, C. (1961). *On becoming a person: A therapist's view of psychotherapy.* Boston, MA: Houghton, Mifflin.

Rogers, C. (1983). *Freedom to learn.* Columbus, OH: C.E. Merrill Publishing Co.

Satir, V. (1975). *Self-esteem.* San Francisco: Celestial Arts.

Satir, V. (1976). *Peoplemaking.* Palo Alto, CA: Science and Behavior Books, Inc.

Stouak, G.E. (1978). *Until we are six: Toward the actualization of our children's human potential.* Huntington, NY: Robert Kruger.

Warren, R.M. (1977). *Caring: Supporting children's growth.* Washington, DC: National Association for the Education of Young Children.

IDENTIFICATION/REFERRAL

Abelson, W., Naylor, A., & Provence, S. (1980). *Teachers' inventory of emotional and behavioral development in children ages 2-6 years.* New Haven, CT: Yale Child Study Center.

Adams, C., & Fay, J. (1982). *He told me not to tell.* Renton, WA: King County Rape Relief Program.

Babich, K. (Ed.). (1986). *Assessing the mental health of children.* Boulder, CO: Western Interstate Commission for Higher Education.

Beaty, J.J. (1986). *Observing development of the young child.* Columbus, OH: Charles E. Merrill Co.

Boehm, A.E., & Weinberg, R.A. (1977). *The classroom observer.* New York: Teachers College Press.

Brazelton, T.B. (1984). *Neonatal Behavioral Assessment Scale* (2nd ed.). Philadelphia, PA: J.B. Lippincott Co.

Caldwell, B.M., & Bradley, R.H. (1987). *Manual for the HOME Observation for Measurements of the Environment.* Little Rock, AK: University of Arkansas.

Cohen, D., & Stern, V. (1978). *Observing and recording the behavior of young children.* New York: Teachers College Press.

Greenspan, S., & Greenspan, N.T. (1985). *First feelings: Milestones in the emotional development of your baby and child.* New York: Viking Penguin.

Hispanic families: A selected bibliography for service providers. (1981). Trenton, NJ: Puerto Rican Congress of New Jersey.

Kubler-Ross, E. (1969). *On death and dying.* New York: MacMillan.

Vontress, C.E. (1971). Racial differences: Impediments to rapport. *Journal of Counseling Psychology, 18,* 7-13.

TREATMENT

Carkhuff, R.R. (1969). *Helping and human relations: A primer for lay and professional helpers.* New York: Holt, Rinehart & Winston.

Clark, J.I. (1984). *Self-esteem: A family affair.* Minneapolis, MN: Winston Press.

Fraiberg, S. (1959). *The magic years -- Understanding and handling the problems of early childhood.* New York: Scribner.

Garbarino, J., Guttmann, E., & Seely, J.W. (1986). *The psychologically battered child.* San Francisco and London: Jossey-Bass.

Jernberg, A. (1980). *Theraplay.* San Francisco: Jossey-Bass.

Samuels, S.C. (1977). *Enhancing self-concept in early childhood: Theory and practice.* New York: Human Sciences Press.

BOOKS FOR CHILDREN

Conford, E. (1971). *Impossible possum.* Boston, MA: Little, Brown & Co.

Hart, C., Rodgers, M., Pagrebin, L.C., & Thomas, M. (Eds.). (1974). *Free to be... you and me.* New York: McGraw-Hill.

Hautzig, D. (1986). *Why are you so mean to me?* New York: Random House.

Hill, S. (1985). *Go away, bad dreams.* New York: Random House.

Kraus, K. (1971). *Leo the late bloomer.* New York: Prentice Hall.

Lionnia, L. (1967). *Frederick.* New York: Alfred A. Knopf.

McBurney-Green, M. (1960). *Is it hard? Is it easy?* Reading, MA: Addison-Wesley.

Viorst, J. (1972). *Alexander & the terrible, horrible, no good, very bad day.* New York: Atheneum.

APPENDIX D

JOURNALS AND ORGANIZATIONS

JOURNALS

American Journal of Orthopsychiatry
49 Sheridan Avenue
Albany, NY 12201
Telephone: 518-436-9686
Subscriptions: $45/year (4 issues)

The Black Child Advocate
National Black Child Development Institute
1463 Rhode Island Avenue, N.W.
Washington, DC 20005
Telephone: 202-387-1281
Subscriptions: $20/year membership fee (4 issues)

Child Care Information Exchange
Box 2890
Redmond, WA 98073
Telephone: 206-883-9394
Subscriptions: $35/year (6 issues)

Child Care Information Service
c/o NAEYC
1834 Connecticut Avenue, NW
Washington, DC 20009
Telephone: 202-232-8777
- A national, centralized source of information about child care.

Subscriptions: $50/year (6 issues)

Child Development
University of Chicago Press
5720 S. Woodlawn Avenue
Chicago, IL 60636
Telephone: 312-702-7600
Subscriptions: $110/year (6 issues)

Childhood Education
Association for Childhood Education International
11141 Georgia Avenue, Suite 200
Wheaton, MD 20902
Telephone: 301-942-2443
Subscriptions: $38 membership fee (5 issues)

Child Psychiatry & Human Development
Human Sciences Press, Inc.
233 Spring Street
New York, NY 10013
Telephone: 212-620-8000
Subscriptions: $105/year (4 issues)

Children Today
Office of Human Development Services
200 Independence Avenue, SW
Room 348-F
Washington, DC 20201
Telephone: 202-472-7257
Subscriptions: $7.50 (6 issues)

Child Welfare
Journal of the Child Welfare League of America
440 First Street, NW
Washington, DC 20001
Telephone: 202-638-2952
Subscriptions: $50/year (6 issues)

Developmental Psychology
1400 N. Uhle Street
Arlington, VA 22201
Telephone: 703-247-7704
Subscriptions: $100/year (6 issues)

ERIC Clearinghouse on Handicapped and Gifted Children
CEC Information Center
The Council for Exceptional Children
1920 Association Drive
Reston, VA 22091
Telephone: 703-620-3660
Subscriptions: $40 (6 issues)

Journal of the American Academy of Child and Adolescent Psychiatry
Subscription Department
Williams & Wilkins
428 E. Preston Street
Baltimore, MD 21202
Telephone: 800-638-6423
Subscriptions: $80/year (6 issues)

Journal of Clinical Child Psychology
Journal Subscription Department
Lawrence Earlbaum Associates
365 Broadway
Hillsdale, NJ 07642
Telephone: 201-666-4110
Subscriptions: $85/year (4 issues)

Journal of Research in Childhood Education
Association for Childhood Education International
11141 Georgia Avenue, Suite 200
Wheaton, MD 20902
Telephone: 301-942-2443
Subscriptions: $20-members; $30-nonmembers (2 issues)

Young Children
National Association for the Education of Young Children
1834 Connecticut Avenue, NW
Washington, DC 20009
Telephone: 202-232-8777
Subscriptions: $20/year-nonmembers (6 issues)

ORGANIZATIONS

Al-Anon/Alateen Family Group Headquarters
PO Box 862
Midtown Station
New York, NY 10018
Telephone: 212-302-7240

Alcoholics Anonymous
15 E. 26th Street, Room 1810
New York, NY 10010
Telephone: 212-683-3900

American Academy of Child and
Adolescent Psychiatry (AACAP)
3615 Wisconsin Avenue, NW
Washington, DC 20016
Telephone: 202-966-7300

American Academy of Pediatrics
PO Box 927
Elk Grove Village, IL 60007
Telephone: 312-228-5005

American Association of
Psychiatric Services for Children
1200-C Scottsville Road, Suite 225
Rochester, NY 14624
Telephone: 716-235-6910

American Council for Drug Education
204 Monroe Street, Suite 110
Rockville, MD 20850
Telephone: 301-294-0600

American Nurses Association
2420 Pershing Road
Kansas City, MO 64108
Telephone: 816-474-5720

American Psychiatric Association
1400 K Street, NW
Washington, DC 20005
Telephone: 202-682-6000

American Psychological Association
1200 Seventeenth Street, NW
Washington, DC 20036
Telephone: 202-955-7601

Association for the Care of
Children's Health (ACCH)
7910 Woodmont Avenue, Suite 300
Bethesda, MD 20814
Telephone: 301-654-6549

The Chemical People/WQED
4802 Fifth Avenue
Pittsburgh, PA 15213
Telephone: 412-622-1491

Children's Defense Fund
122 C Street, NW
Washington, DC 20001
Telephone: 202-628-8787

Clearinghouse on Child Abuse and
Neglect Information
PO Box 1182
Washington, DC 20013
Telephone: 703-821-2086

Coalition of Hispanic Health and Human Services
Organizations (COSSMHO)
1030 15th Street, NW, Suite 1053
Washington, DC 20005
Telephone: 202-371-2100

COCANON Family Groups (Recorded Information)
PO Box 64742-66
Los Angeles, CA 90064
Telephone: 213-859-2206

ERIC Clearinghouse on Elementary
and Early Childhood Education
University of Illinois
College of Education
805 West Pennsylvania Avenue
Urbana, IL 61801
Telephone: 217-333-1386
(Free Newsletter)

Families Anonymous, Inc.
PO Box 528
Van Nuys, CA 91408
Telephone: 818-989-7841

Institute of Black Chemical Abuse
2616 Nicolet Avenue
Minneapolis, MN 55408
Telephone: 612-871-7878

International Association for
Infant Mental Health (IAIMH)
Michigan State University
Department of Psychology
Psychology Research Building
East Lansing, MI 48824-1117
Telephone: 517-355-4599

Just Say No Foundation
1777 North California Boulevard
Room 210
Walnut Creek, CA 94596
Telephone: 415-939-6666

C. Henry Kempe National Center
for the Prevention and Treatment
of Child Abuse and Neglect
University of Colorado Health Sciences Center
Department of Pediatrics
1205 Oneida
Denver, CO 80220
Telephone: 303-321-3963

Mental Health Law Project (MHLP)
2021 L Street, NW. Suite 800
Washington, DC 20036-4909
Telephone: 202-467-5730

Mothers Against Drunk Driving Central Office
511 E. John Carpenter Freeway
Suite 700
Irving, TX 75062
Telephone: 214-744-6233

Nar-Anon Family Group Headquarters
World Service Office
PO Box 2562
Palos Verdes Peninsula, CA 90274-0119
Telephone: 213-547-5800

National Alliance for the Mentally Ill (NAMI)
2101 Wilson Boulevard, Suite 302
Arlington, VA 22201
Telephone: 703-524-7600

National Association for Children of Alcoholics
31582 Coast Highway, Suite B
South Laguna Beach, CA 92677
Telephone: 714-499-3889

National Association of Social Workers
7981 Eastern Avenue
Silver Spring, MD 20910
Telephone: 301-565-0333

National Association of State
Alcohol and Drug Abuse Directors
444 N. Capitol Street, NW, Suite 520
Washington, DC 20001
Telephone: 202-783-6868

National Association of State
Mental Health Program Directors
1101 King Street, Suite 160
Alexandria, VA 22314
Telephone: 703-739-9333

National Center for Clinical
Infant Programs (NCCIP)
2000 14th Street North, Suite 380
Arlington, VA 22201
Telephone: 703-528-4300

National Clearinghouse for
Alcohol and Drug Information
PO Box 2345
Rockville, MD 20852
Telephone: 301-468-2600

National Council of Community
Mental Health Centers
6101 Montrose Road, Suite 360
Rockville, MD 20852
Telephone: 301-984-6200

National Council on Alcoholism
1511 K Street, NW, Suite 320
Washington, DC 20005
Telephone: 202-737-8122

National Depressive and
Manic Depressive Association
53 W. Jackson Boulevard, Suite 505
Chicago, IL 60604
Telephone: 312-939-2442

National Early Childhood Technical
Assistance System (NEC*TAS)
CB #8040
500 NCNB Plaza
Chapel Hill, NC 27599-8040
Telephone: 919-962-2001

National Families in Action
Drug Information Center
2296 Henderson Mill Road, Suite 204
Atlanta, GA 30345
Telephone: 404-934-6364

The National Foundation for Depressive Illness
20 Charles Street
New York, NY 10014
Telephone: 212-620-7637

National Head Start Association
Executive Director, National Office
1220 King Street, Suite 200
Alexandria, VA 22314
Telephone: 703-739-0875

National Information Center for
Children and Youth with Handicaps
PO Box 1492
Washington, DC 20013
Telephone: 703-522-3332

National Institute of Mental Health
Public Inquiries
5600 Fishers Lane, Room 15C-05
Rockville, MD 20857
Telephone: 301-443-4513

National Institute on
Alcohol Abuse and Alcoholism
5600 Fishers Lane, Room 16-105
Rockville, MD 20857
Telephone: 301-443-3885

National Institute on Drug Abuse (NIDA)
5600 Fishers Lane, Room 10-05
Rockville, MD 20857
Telephone: 301-443-6480

- NIDA has established a toll-free helpline to provide information to employers. The number is 800-843-4971, and operates Monday through Friday from 9 am to 8 pm Eastern Time.

- NIDA also operates a toll-free Drug Abuse Information and Treatment Referral line, 1-800-662-HELP, to provide individuals with drug related information, and facilitate the placement of drug users in treatment programs.

- Since August 1988, bilingual Hotline staff have been responding to Spanish speaking callers on a separate dedicated line, 1-800-66-AYUDA. The Spanish Hotline number will be included on all Spanish-language print materials and radio PSA's.

- NIDA has begun a major AIDS and intravenous (IV) drug use public education campaign. It is designed to educate and inform IV drug users of their risks and encourage them to get treatment. Since January 1987, Hotline staff have been trained to talk about AIDS to callers if they are intravenous drug users--1-800-662-HELP.

National Mental Health Association (NMHA)
1021 Prince Street
Alexandria, VA 22314-2971
Telephone: 703-684-7722

National Network of Parent Centers (NNPC)
1234 Massachusetts Avenue, Suite C1017
Washington, DC 20005
Telephone: 202-783-0125

National Parents Resource Institute
for Drug Education (PRIDE)
Robert W. Woodruff Volunteer Service Center
50 Hurt Plaza, Suite 210
Atlanta, GA 30303
Telephone: 404-651-2548

National Prevention Network
444 North Capitol Street, NW
Suite 642
Washington, DC 20001
Telephone: 202-783-6868

World Association for Infant Psychiatry
and Allied Disciplines (WAIPAD)
The Vision of Child Psychiatry
Louisiana State University Medical Center
1542 Tulane Avenue
New Orleans, LA 70112-2822
Telephone: 504-568-6001

★U.S. GOVERNMENT PRINTING OFFICE: 1990 - 261-135/24556