

# **The Benefits of Integrated Mental Health Consultation in Head Start:**

## **A Qualitative Inquiry**

Beth L. Green, Ph.D.

*NPC Research, Inc.*

Jennifer Simpson, Ph.D.

Maria C. Everhart

Elizabeth Vale

*Portland State University*

RUNNING HEAD: Integrated Mental Health Consultation

Correspondence should be addressed to the first author at: NPC Research, Inc. 5200 SW Macadam Ave., Portland, OR, 97201; email: [green@npcresearch.com](mailto:green@npcresearch.com). (503\_243-2436).

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#### **Abstract**

Despite mandates for Head Start programs to provide mental health services to families and children, considerable variability remains in the level of services provided by mental health consultants. A qualitative study was conducted to explore whether having mental health consultants who were more available to staff and more integrated into overall program functioning was related to more effective mental health programming. Results suggested that programs with a more integrative mental health model were more likely to have a strong, unified vision for mental health services, to have a mental health approach consistent with current best practices, and to perceive their mental health services to be more effective.

## **Introduction**

In 1994, Piotrkowski, Collins, Knitzer, and Robinson called for a “paradigm shift” in the way that Head Start programs address the mental health needs of children and families. Effective mental health services for the Head Start population, they argued, should not rely on traditional problem-focused services provided by clinicians outside of the program context. Instead, services should take a holistic approach, emphasizing prevention, family involvement, staff development, and integration of mental health services with other Head Start components (Piotrkowski et al, 1994). Revised Head Start performance standards (U.S. Department of Health and Human Services, 1996) began to address this new approach by requiring a comprehensive, family-focused approach to delivering mental health services, including "sufficient" mental health consultation to meet the needs of all Head Start children. Despite these standards, the nature of mental health consultation varies widely across Head Start programs, with many programs continuing to take a traditional, narrow view of mental health (Yoshikawa & Knitzer, 1997).

At its best, mental health consultation supports a program’s well-established vision of comprehensive, family-focused, prevention-oriented mental health services by providing ongoing support to staff and families (Yoshikawa & Knitzer, 1997). However, many programs have continued to struggle to develop satisfactory consulting relationships, due at least in part to difficulties obtaining qualified staff, resource issues, complex organizational issues (e.g., difficulties establishing clear roles and responsibilities), and value conflicts or absence of a consistent program vision for

providing mental health services that incorporates this paradigm shift (Cohen & Kaufman, 2000). Consultants are often used in limited ways (e.g., only for time-limited observations and assessments), and are not considered a core part of ongoing service delivery to all families.

A number of experts have suggested that effective mental health services for Head Start and other early childhood programs must be delivered in a way that is integrated with other program services. That is, rather than being seen as a ‘stand alone’ component, isolated from other services, mental health issues should be addressed holistically. To facilitate this integration, Yoshikawa and Knitzer (1996) urge programs to involve mental health professionals on-site and in an expanded role in program delivery (for example, as participants in program planning and management meetings) (Yoshikawa & Knitzer, 1996). Having mental health consultants who can continually bring mental health issues to the table, ensure mental health issues are addressed during planning, and who are able to dialogue and support staff through informal daily contact is thought to help staff at all levels have a broader understanding of mental health, and to integrate mental health issues into more aspects of program functioning. However, there has been little empirical work to document the benefits of involving mental health consultants in multiple levels of program functioning. The purpose of this study was to begin to explore, in the context of three Head Start programs, the programmatic benefits of having mental health consultants who are well-integrated into service delivery and program management.

Involving a mental health consultant (or consultants) in broader Head Start program functioning requires addressing several issues. First, it implies that the

consultant is available and accessible to program staff for consultation as issues arise. This is in contrast to a model in which consultants are contracted to provide specific, rigidly defined services (e.g., to provide a particular number of child assessments). An integrated model also involves consultants who are able to provide a variety of types of support to staff, including consultation regarding specific children or families, as well as more general classroom management assistance and support to staff in their professional roles (Cohen & Kaufman, 2000). Thus, the role of the consultant needs to be broadly, rather than rigidly defined.

Although amount of time and breadth of responsibilities of the consultant are key structural factors, the quality of the relationship between mental health consultants and program staff is likely to be even more important in supporting effective mental health service delivery (Bertacchi, 1996; Cohen & Kaufman, 2000; Knitzer, 1999). Mental health consultants must develop trust and rapport with program staff, working in partnership with them to address families' needs (Bertacchi, 1996; Epps, Donahue, Leaf, & Koretz, 1999). As Epps et al. (1999) suggest, it is critical that mental health consultants not "come in as the 'fix-it' person, the professional who will make the children better behaved" (p. 246). Rather, consultants need to work collaboratively with parents, teachers, and other staff. In a Head Start context, it is also important that consultants share the program's values of parent involvement, prevention, and strengths-based approaches. Similarly, staff need to perceive that consultants have appropriate expertise, especially in dealing with young children from families of different cultures and of low socio-economic status (Cohen & Kaufman, 1996), in order to be seen as credible.

Having an integrated model of mental health consultation yields several potential benefits to programs. One of the most important is the diffusion throughout a program of what Cohen and Kaufman (2000) refer to as a “mental health perspective” that is based in a preventative, family-focused, holistic approach to mental health. Consultants who bring this philosophy of mental health to the program can help to train staff (formally and informally) thus ensuring that this vision reaches all levels of staff. Thus, the consultant builds on these core Head Start principles and helps staff to see how these principles apply to mental health issues.

Consultants who play an active role in program development and strategic planning may also help programs to convert this perspective or philosophy into an articulated program vision for mental health. It has been suggested that having a clear, unified vision for mental health is a critical foundation for quality mental health program. Such a vision should define mental health issues holistically, convey a message to staff that mental health is an issue that cuts across all program components, and provide the basis for making decisions about the best ways to provide mental health services (Cohen & Kaufman, 2000). Such a vision may also help programs to better articulate their goals for mental health services, and to see the linkages between their program activities and positive mental health outcomes, thus increasing the effectiveness of these services (Weiss, 2000).

In addition to helping programs develop and disseminate a holistic mental health philosophy and clearly articulated set of program goals, having highly involved mental health consultants is likely to support mental health programming in other ways as well. Integrated mental health consultants are likely to increase the effectiveness of mental

health services by playing a broader role in a variety of mental health activities, and thus providing a number of 'avenues of influence' through which positive changes in children and families can be approached (Cohen & Kaufman, 2000; Epps et al, 1999).

Effectiveness is also likely to be enhanced simply by having the consultant more available to staff for informal consultation, especially if staff have a trusting relationship with the consultant. Staff may be more likely to use a consultant's services for issues as they arise if they feel they can "pick up the phone" and get assistance, support, and answers to questions without feeling as if their professional competence is compromised by seeking help (Epps et al, 1999).

The purpose of the present study is to explore these potential benefits of an integrated model of mental health consultation. Although such benefits have been suggested by a number of authors, little work has been done to empirically document the purported effects of having mental health consultants who are involved more broadly in program functioning. Because such an approach is typically more resource intensive, it is important to provide evidence that this model, as opposed to more traditional consultative models, provides value added to Head Start programs. Using qualitative methods, we examined whether having an integrated model of mental health consultation was related to:

- (1) The extent to which program staff have a good understanding of a holistic approach or philosophy of mental health.
- (2) The ways in which staff think about mental health issues.
- (3) The kinds of goals staff have for mental health services.
- (4) The types of mental health activities and services provided.

(5) Staff perceptions of mental health service effectiveness.

## **Methods**

### Participants

Participants were recruited from three different Head Start programs in the Pacific Northwest. Three programs were chosen to represent different approaches to mental health consultation in Head Start, as well as different population groups (rural/urban, and programs serving different racial/ethnic groups). Following an initial meeting with program administrators to discuss the research project, each program selected a subset of their sites for inclusion in the study. Research staff encouraged program administrators to choose sites that represented their program well (i.e., were "typical" sites for their program). Researchers interviewed a total of 63 staff in five sites within three programs. Researchers interviewed all program administrators (N=8), management staff affiliated with the selected sites (N=8); and a convenience sample of remaining site staff, including: family services advocates (N=10); mental health consultants (N=7); teachers (N=13); teachers' assistants (N=15); other staff, including bus drivers and custodians (N=2).

### Setting

Program A is an urban Head Start located and administered within a large urban school district, and serving children in six school-based sites. Program B is a stand-alone program serving families in ten sites in an outlying metropolitan area. Program C is a rural site serving children in nine sites in three different counties. The programs serve children and families primarily from European American, African American, Hispanic, and Native American backgrounds. Each of the programs had a different history with and

approach to the use of mental health consultants. Program A employed one private consultant in a primary role, as well as a second contracted through a county agency, for a total of 1712 hours per school year (1 full-time equivalency) for 560 children. Program B had four consultants contracted through a county mental health agency, for a total of 5120 hours per school year (about 3.2 FTE), serving 551 children. Program C had several mental health consultants from different agencies in different counties, and each site contracted for 5-15 hours per classroom per year (about .07 FTE total), serving a total of 247 children.

Programs also varied in the degree to which mental health consultants were integrated into classroom and organizational life. Mental health consultants in Programs A and B had a prominent role, and were involved in administrative functioning. They attended management team meetings, were frequent participants in classrooms, provided formal and informal training to teachers, and participated in other ways with the comprehensive Head Start program. In Program C, three contracted mental health consultants provided basic services (classroom observations and assessments) to the program.

### Procedure

The interviews lasted between 45 to 90 minutes, were conducted individually and in person, and followed a semi-structured, open-ended interview format depending on the role the person played in the Head Start program. It should be noted that because the interviews were designed to be qualitative and somewhat conversational, not all participants responded to every question or completed the entire set of questions. The interviews were designed to explore how staff members conceptualized and approached mental health issues in their work, family involvement in mental health services, and

parental/caregiver beliefs about mental health. Interview topics included: program philosophy, mental health philosophy, organizational variables, communication, working with families, program resources, decision-making, outcomes, and contextual factors.

## **Results**

### **Coding and Reliability**

Interviews were audio-recorded, and notes were transcribed and entered into a qualitative data analysis software package, Non-Numerical Unstructured Data-Indexing, Searching, and Theorizing (NUD\*IST). NUD\*IST allows the answers to interview questions to be categorized according to coding schemes while preserving the original text of the answers, so that both quantitative-type analyses (e.g., counts) can be conducted, as well as interpretation of the text responses. A coding scheme was developed for each question, based on the a priori variables of interest. Three members of the research team then coded a sample of 5 interviews and compared these results. Areas of disagreement were discussed, and consensus reached about how to code answers. An additional 3 interviews were coded to ensure 85% inter-rater reliability. Two of the three researchers then coded the remaining interviews, with periodic checks to ensure consistency across coders. Target variables were coded from the following questions:

1. Would you say that this program has a particular approach or philosophy about how best to support children's mental health? If so, what is the philosophy?
2. What kinds of things do you do in your role here to promote mental health for children, families, and staff?

3. In your program, who would you say is responsible for mental health services and activities?
4. To what extent do you feel the mental health person is accessible and available when you need him/her?
5. How would you describe your relationship with the mental health consultant?
6. What do you think are the most important goals of your mental health approach?
7. To what extent do you think your program's mental health approach is working effectively? Why or why not?
8. What changes do you hope to see in children, families and staff as a result of your mental health approach?

Using the process described above, the following variables were coded:

- A. Presence of a clear mental health philosophy or perspective

(yes/somewhat/no)

- B. Content of the philosophy with regard to mental health services (responses

could be coded in multiple categories):

- (1) integration of mental health with other services
- (2) child/classroom focused
- (3) prevention/strengths oriented
- (4) parent involvement oriented
- (5) focused on connecting families to community services

- C. What does the mental health consultant (MHC) do to promote mental

health for children, families, and staff (responses could be coded in multiple categories):

- (1) MHC does classroom observations
- (2) MHC does individual child observations
- (3) MHC provides written feedback to teachers
- (4) MHC talks with teachers
- (5) MHC provides direct mental health services

D. Who is responsible for mental health activities?

- (1) line staff
- (2) management and staff
- (3) MHC
- (4) everyone

E. What type of goals do staff see for the mental health activities?

- (1) Services goals (provision of services)
- (2) Child and family outcomes or changes

F. What are the child and family-related goals of the mental health activities?

- (1) general wellness and well-being
- (2) help the child and family feel valued
- (3) help the child feel good about him/her self
- (4) help the family move toward planned goals
- (5) social competency
- (6) school readiness

G. Is the program's mental health approach working?

- (1) working well
- (2) working somewhat
- (3) not working well

Matrices were constructed in NUD\*IST examining the relationship between the key outcomes and three related variables reflecting the level of involvement of the mental health consultant: (1) *type of contact* with the mental health consultant, rated as either “minimal” (e.g., structured, formal, interactions based on a contractual arrangement for specific, pre-specified services) or “moderate/strong<sup>1</sup>” (e.g., a contractual relationship, but available on an as-needed basis for additional consultation, or sees MHC as “part of program staff”); (2) *Quality of relationship* between the program staff and the mental health consultant, rated as either “good” (e.g., trusting, collaborative, positive) or

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<sup>1</sup> Two categories of “moderate” and “strong” were collapsed because only three individuals were rated in the “moderate” category.

“distant” (e.g., no relationship, few interactions, limited contact); (3) *level of accessibility* of the MHC, rated as “very” (e.g., available whenever needed), “somewhat” (available, but with caveats, e.g., sometimes difficult to get in touch with), or “not very” (e.g., little or no contact, don’t ever contact the MHC, etc.). Note that although we selected programs with *a priori* high and low levels of integration of the MHC, we chose to analyze our results at the individual level. In this way we could examine whether, within a given program, individuals at different levels and with different roles (e.g., line staff vs. management) might have different understandings and perceptions of mental health and mental health services. Tables 1, 2 & 3 present these matrices.

These tables, consisting of counts of responses, comprised the foundation for our analyses. Matrices were examined by four members of the research team independently to identify patterns in the data. Patterns were then discussed and consensus reached about the presence (or absence) of a particular pattern in the data. Because we had three questions that were related to the over-arching issue of the level of involvement and integration of the mental health consultant, we used the patterns of responses to these three questions to triangulate our conclusions; more weight was given to findings that were consistent across the three indicators of mental health involvement. However, notable differences in patterns between the three indicators of involvement are also discussed. The patterns of results are summarized below.

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Insert Tables 1, 2, & 3 about here

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**Presence and content of program’s philosophy of mental health.** Persons who perceived the MHC to be more involved were generally more likely to report that their program had a particular approach or philosophy focused on children’s mental health services, compared to those who perceived the MHC as being less involved. Further, the content of the philosophy or approach was more likely to be focused on integrating mental health services with other program components. Stated one staff member who perceived the consultant as highly involved, “it [mental health] is integrated into all aspects of the program from direct services to children and families, to consultation and support of staff, management, and program planning. I also see it integrated into all the components of Head Start. I don’t think we view mental health as a separate component.” Persons who perceived higher levels of involvement of the MHC were also less likely to articulate a “child or classroom focused” approach to mental health and instead focused more on parent involvement. “Child focused” responses placed the primary emphasis on child behavior, especially in the classroom setting, as the central component of the mental health approach. “Child focused” language also tended to emphasize problem behavior and its amelioration. This suggests that persons perceiving higher levels of involvement by the MHC had internalized a philosophy about mental health that was more consistent with current best practices. There were no differences between respondents who reported high vs. low levels of involvement in terms of articulating a philosophy focused on more general principles of preventative practice (e.g., strengths-orientation, individualization, relationship-based practices).

**Mental health consultant activities.** Again, a pattern of differences emerged that suggested that in cases of higher levels of MHC involvement, consultants were more

likely to be engaged in a range of activities that included direct interactions with teachers as well as providing direct services. Persons who saw the MHC as being less involved talked mostly about the consultant's role in providing specific, concrete tasks such as child and classroom observations, e.g., "we arrange for a mental health professional to observe classes two times per year, and make that mental health professional available to observe children who need it". In contrast, persons who saw the mental health consultant as highly involved saw multiple roles and activities as part of this persons job, e.g., "We've always had mental health consultants available at staff meetings and for staff...They work with our site teams. They work with the staff and kids. They work with the specialists on curriculum and training." This may be a reciprocal relationship, as consultants who are more integrated and involved are more likely to go beyond the basic consultation function (assessments and observations) to provide less formal, as-needed assistance to teachers, as well as more direct service to families. This range of roles may be one reason why involvement may be linked to more effective services. Finally, persons who did not see the MHC as highly involved were somewhat more likely to mention connecting families with community services as a primary mental health activity.

**Responsibility for mental health.** Persons who saw the MHC as more involved were generally more likely to see "everyone" as being responsible for children's mental health, and/or to see the MHC as responsible. This suggests that these persons see mental health as more integrated across staff roles and functions, rather than being isolated within a specific individual. It is not surprising that among those who do not see the MHC as involved do not see this person as being responsible for mental health services.

However, it did appear that in programs with a larger role for the MHC, there is also more work done to establish clear lines of responsibility and clarification of roles. For example, one MHC stated that “The teacher and I (the MHC) [are responsible], but also the teacher’s assistant. We need to be coordinating what’s happening in the classroom with the families, in the trainings I give parents, the family partnerships that I do, plus the home visits that the teachers are doing, as well as the goals for the children and the classroom curriculum. We all need to be aware of what the other one is doing, the whole major picture of this family”. This individual clearly saw lines of responsibility, and the need for clear roles and communication around how to accomplish mental health goals. Individuals at low involvement programs were more likely to simply state “Everyone is responsible” without elaborating on how this is accomplished.

**Program goals.** Persons who reported a strong relationship with the MHC generally focused more on goals related to changes in child and family functioning, and less on service-related goals. This could also be related to the finding that persons reporting a more limited role of the MHC were more likely to talk about connecting families to community services as one of their mental health activities. Programs without a strong MHC may be more likely to adopt this kind of “resource and referral” model because they do not have a strong MHC who can provide direct services.

**Program effectiveness.** Persons reporting higher levels of MHC involvement were generally likely to see the program as working effectively. For example, one “low involvement” respondent stated, “we do have the MHC, but trying to work with [him/her] is a drop in the bucket.” Another individual who perceived lower levels of involvement responded, “It is effective to the point of what is realistic, given budget and resource

limits. I wish we had more consultation, on site or more accessible to families in an ongoing basis rather than as a “one shot.” Persons who perceive the MHC as being more involved, however, may also be more likely to have an investment in seeing the mental health services work, perhaps because they need to justify the allocation of resources to the MHC. These persons may also be more familiar with the work of the MHC, and to see the benefits. As one person stated, “Overall, it is working very effectively. The reason why is the positive outlook on mental health in every aspect of our program, and the extent of involving staff and families. That is the key.”

### **Discussion**

In general, these findings suggest that having consultants who are more involved in program functioning does provide programmatic benefits, especially in terms of supporting a unified, holistic vision of mental health that avoids compartmentalization of mental health issues, and which embraces best practice notions such as parent involvement and integration of services. Further, staff who perceived higher levels of consultant involvement also felt that those services were more effective. Patterns of results were generally stronger for analyses based on the *type of contact* and *quality of relationship* than was the case for *level of accessibility*. This suggests that the amount of time available for the consultant may be less important than the way that time is structured or the quality of relationship. This interpretation is borne out by anecdotal evidence from Program C, in which three different consultants were used by three different sites. Although all had contracts for the same roles and number of hours, one consultant had been working with the program for a number of years, was seen as highly credible and experienced in working with Head Start families, and made herself available

for informal communication in addition to the formal contracted time. At this site, there was more evidence of a mental health approach that was similar to the other, more integrated programs. Having a mental health consultant who is perceived as being “part of the program” and whom staff feel they can trust appears to be more important than simply the amount of time available for consultation.

One hypothesis of the current study was that having a strong, well-articulated and widely understood philosophy that is grounded in best practices related to early childhood mental health is an important cornerstone for effective mental health services. It appears that having a mental health consultant who is well-integrated into program functioning and who is perceived as being available and accessible by staff is related to having a clear philosophy that is understood across different levels of staff. While these data do not suggest the pattern of causality (programs that have such a holistic philosophy may more systematically involve the mental health consultant and design programmatic ways to ensure high levels of involvement from this individual) it seems likely that the relationship is reciprocal. That is, having a mental health consultant who is more involved in program functioning and who has more contact with staff (both formal and informal) can either start the process of developing a more consensus-based and pervasive approach, or can reinforce an existing one. However, it should be noted that the philosophy or approach of the mental health consultant must be consistent with best practices. These data suggest that alignment of the MHC's approach with Head Start program values is important.

Because we had chosen programs purposefully to represent high and low levels of mental health consultant integration, we also examined patterns of differences across the

three programs. However, these results were much less clear-cut, suggesting that even within programs with high levels of mental health integration, there is considerable variability in the extent to which all staff have a shared understanding of children's mental health and mental health services. For example, even within the program with the highest level of mental health involvement (based on amount of consultant time and how the consultative relationship was structured), there continued to be staff who did not articulate a holistic approach to mental health, and who felt the mental health services were not particularly effective. These persons also tended to perceive lower levels of mental health involvement. This finding underscores the importance of ensuring that *all* staff have sufficient contact with the MHC, and receive both formal and informal training in the program's mental health approach and philosophy.

Several caveats must be offered in regards to these findings. First, the study is based on a small sample of only three Head Start programs, and thus it is possible that these results are idiosyncratic to these specific programs or consultants. This possibility is reduced somewhat by our method of analysis (at the individual, rather than program, level) and by the fact that at least seven different consultants work with these three programs. Second, relatively small numbers of individuals account for some of the variability in responses for some of the research questions. This is due to the nature of the qualitative inquiry, in which a conversational approach allowed interviewers considerable latitude in terms of which questions were asked of various individuals. Clearly, studies involving larger samples with more structured protocols are important to strengthen confidence in these conclusions. Third, these data are cross-sectional. It is impossible to know the direction of causality with certainty; it may be the case that

programs that have a clear, well-articulated philosophy and an effective approach are more likely to purposefully structure consultation in a way that enhances MHC involvement, rather than MHC involvement leading to a stronger, better understood philosophy and more effective services. Prospective research that tracks programmatic changes over time is needed to disentangle these issues. Finally, this study does not directly address the question of whether increased MHC involvement leads to improved outcomes for individual children or families. This is a critical question for future research.

### ***Implications***

The results of this study support several recommendations for programs seeking to enhance their mental health services, and make efficient use of limited mental health dollars. First, the quality of relationship between mental health consultants and program staff is of central importance. Having a mental health consultant who is trusted, who makes him/herself accessible to staff, and who is perceived as being “part of the team” appears to be more important than the actual number of hours a consultant is available. Second, these results suggest that having clear vision and approach to mental health services, that is well understood by all staff, is important to effective mental health services. Consultants can play a supportive role in developing and/or supporting such a program vision, by working both formally and informally with staff to ensure that children’s mental health issues are addressed appropriately.

Finally, these results suggest that different programs may want to consider different models of mental health consultation. Cohen and Kaufman (2000) distinguish between child- or family-centered consultation and programmatic consultation. The

former is the more traditional form, in which staff seek assistance from the consultant in regards to a specific child or family. Programmatic consultation involves training staff, working with the program on quality improvement, and providing support to staff in their work with families. Although all of the programs included in this study utilized a primarily child/family-centered model, elements of programmatic consultation were in place, especially for the two programs with more integrated models. Training provided was primarily informal, working with teachers on classroom management issues. Quality improvement work happened through the role consultants played on management teams. This research suggests that programmatic consultation is equally important as child/family centered consultation, in that it may help to further disseminate the mental health perspective throughout an organization. A more formalized programmatic consultation role could be especially effective in helping to ensure that a mental health perspective is integrated across program components. In this way, mental health consultation moves beyond individual child or family treatment, and towards programmatic capacity building, a key shift for programs with limited mental health resources.

Table 1. Type of Contact with Mental Health Consultant

Target Variable	Type of Contact	
	Infrequent & Restricted	Frequent & Unrestricted
<b>A. Presence of Philosophy?</b>		
(1) Yes	17% (2)	33% (2)
(2) Somewhat	33% (4)	50% (3)
(3) No	50% (6)	11% (1)
<b>B. What is Philosophy<sup>2</sup>?</b>		
(1) integration of mental health with other services	25% (3)	67% (4)
(2) child/classroom focused	25% (3)	17% (1)
(3) prevention/strengths orientation	83% (10)	67% (4)
(4) parent involvement	75% (9)	67% (4)
(5) connect families to community services	33% (4)	17% (1)
<b>C. What does the MHC do to promote MH for children, families, and staff<sup>2</sup>?</b>		
(1) classroom observations	92% (11)	100% (6)
(2) child observations	58% (7)	50% (3)
(3) MHC provides written feedback to teachers	42% (5)	50% (3)
(4) MHC talks with teachers	33% (4)	100% (6)
(5) MHC provide direct mental health services	25% (3)	83% (5)
<b>D. Who is responsible for mental health activities<sup>2</sup>?</b>		
(1) line staff	8% (1)	17% (1)
(2) management and staff	17% (2)	50% (3)
(3) MHC	0% (0)	33% (2)
(4) everyone	50% (6)	33% (2)
<b>D. What type of goals do staff see for the mental health activities<sup>2</sup>?</b>		
(1) services goals (provide services)	42% (5)	67% (4)
(2) child and family outcomes or changes	50% (6)	83% (5)
<b>E. What are the child and family-related goals of the mental health activities<sup>2</sup>?</b>		
(1) general wellness and well-being	17% (2)	33% (2)
(2) help the child and family feel valued	8% (1)	17% (1)
(3) help child feel good about him/her self	8% (1)	33% (2)
(4) help family move toward planned goals	25% (3)	17% (1)
(5) social competency	8% (1)	33% (2)
(6) school readiness	8% (1)	0% (0)
<b>G. Is the program working?<sup>3</sup></b>		
(1) working well	n/a	n/a
(2) working somewhat	n/a	n/a
(3) not working well	n/a	n/a

<sup>2</sup> multiple responses coded

<sup>3</sup> This analysis was not possible because none of the respondents in the “frequent” contact category provided answers to this question.

**Table 2. Quality of Relationship of Mental Health Consultant**

Target Variable	Quality of Relationship with MHC	
	Distant	Good
<b>A. Presence of Mental Health Philosophy?</b>		
(1) Yes	15% (2)	38% (6)
(2) Somewhat	38% (5)	44% (7)
(3) No	46% (6)	19% (3)
<b>B. What is the Mental Health Philosophy<sup>4</sup>?</b>		
(1) integration of mental health with other services	15% (2)	44% (7)
(2) child/classroom focused	77% (10)	38% (6)
(3) prevention/strengths orientation	15% (2)	25% (4)
(4) parent involvement	31% (4)	44% (7)
(5) connect families to community services	23% (3)	6% (1)
<b>C. What does the MHC do to promote MH for children, families, and staff<sup>4</sup>?</b>		
(1) classroom observations	38% (5)	19% (3)
(2) child observations	15% (2)	19% (3)
(3) MHC provides written feedback to teachers	15% (2)	19% (3)
(4) MHC talks with teachers	7% (1)	25% (4)
(5) MHC provide direct mental health services	7% (1)	13% (2)
<b>D. Who is responsible for mental health activities<sup>4</sup>?</b>		
(1) line staff	7% (1)	19% (3)
(2) management and staff	23% (3)	19% (3)
(3) MHC	0% (0)	31% (5)
(4) everyone	15% (2)	38% (6)
<b>E. What type of goals do staff see for the mental health activities<sup>4</sup>?</b>		
(1) services goals (provide services)	61% (8)	31% (5)
(2) child and family outcomes or changes	61% (8)	94% (15)
<b>F. What are the child and family-related goals of the mental health activities<sup>4</sup>?</b>		
(1) general wellness and well-being	31% (4)	31% (5)
(2) help the child and family feel valued	0% (0)	19% (3)
(3) help child feel good about him/her self	15% (2)	12% (2)
(4) help family move toward planned goals	23% (3)	19% (3)
(5) social competency	31% (4)	38% (6)
(6) school readiness	0% (0)	19% (3)
<b>G. Is the program working?</b>		
(1) working well	38% (3)	55% (6)
(2) working somewhat	50% (4)	27% (3)
(3) not working well	13% (1)	18% (2)

<sup>4</sup> multiple responses coded

Table 3. Accessibility of Mental Health Consultant

Target Variable	Accessibility of MHC		
	not very	somewhat	very
<b>A. Presence of Mental Health Philosophy?</b>			
(1) Yes	28% (4)	38% (5)	18% (2)
(2) Somewhat	28% (4)	23% (3)	73% (8)
(3) No	43% (6)	38% (5)	9% (1)
<b>B. What is Mental Health Philosophy<sup>4</sup>?</b>			
(1) integration of mental health with other services	28% (4)	23% (3)	18% (2)
(2) child/classroom focused	50% (7)	23% (3)	36% (4)
(3) prevention/strengths orientation	36% (5)	46% (6)	36% (4)
(4) parent involvement	50% (7)	23% (3)	45% (5)
(5) connect families to community services	28% (4)	8% (1)	9% (1)
<b>C. What does the MHC do to promote MH for children, families, and staff<sup>4</sup>?</b>			
(1) classroom observations	50% (7)	30% (4)	18% (2)
(2) child observations	28% (4)	23% (3)	18% (2)
(3) MHC provides written feedback to teachers	28% (4)	8% (1)	18% (2)
(4) MHC talks with teachers	21% (3)	15% (2)	36% (4)
(5) MHC provide direct mental health services	7% (1)	23% (3)	18% (2)
<b>D. Who is responsible for mental health activities<sup>4</sup>?</b>			
(1) line staff	7% (1)	15% (2)	9% (1)
(2) management and staff	14% (2)	30% (4)	18% (2)
(3) MHC	0%	30% (4)	18% (2)
(4) everyone	36% (5)	23% (3)	72% (8)
<b>E. What type of goals do staff see for the mental health activities<sup>4</sup>?</b>			
(1) services goals (provide services)	28% (4)	54% (7)	54% (6)
(2) child and family outcomes or changes	71% (10)	54% (7)	73% (8)
<b>F. What are the child and family-related goals of the mental health activities<sup>4</sup>?</b>			
(1) general wellness and well-being	28% (4)	23% (3)	27% (3)
(2) help the child and family feel valued	7% (1)	0%	18% (2)
(3) help child feel good about him/her self	21% (3)	0%	18% (2)
(4) help family move toward planned goals	14% (2)	8% (1)	27% (3)
(5) social competency	21% (3)	38% (5)	18% (2)
(6) school readiness	21% (3)	15% (2)	9% (1)
<b>G. Is the program working?</b>			
(1) working well	28% (4)	31% (4)	36% (4)
(2) working somewhat	21% (3)	15% (2)	18% (2)
(3) not working well	14% (2)	8% (1)	0%

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