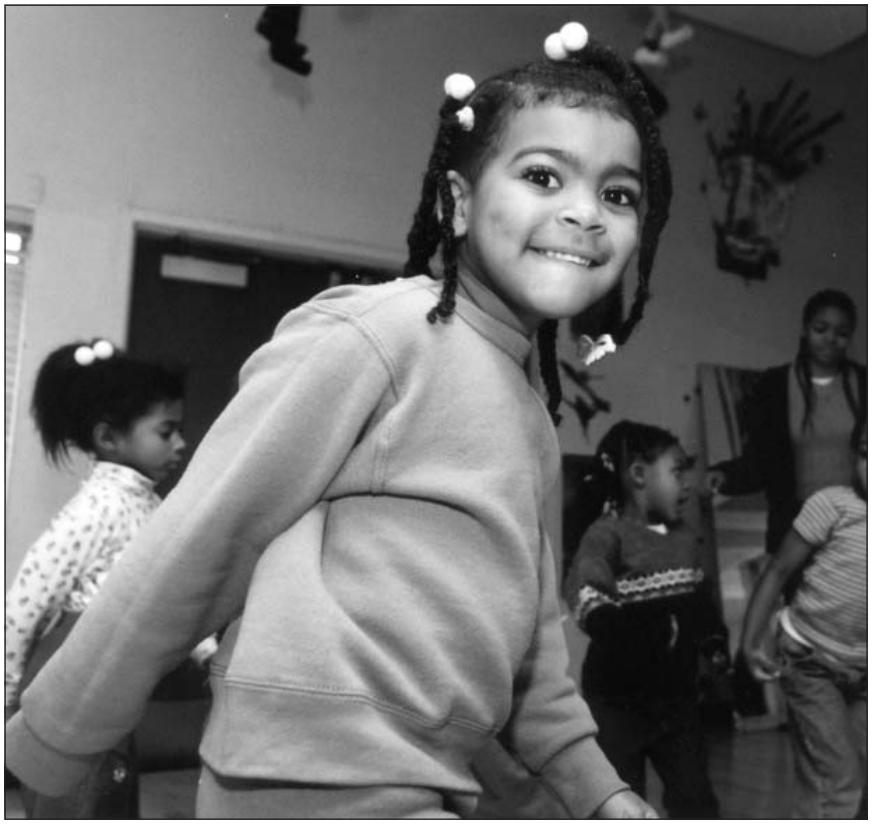
Behavioral Health



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California Childcare Health Program

The mission of the California Childcare Health Program is to improve the quality of child care by initiating and strengthening linkages between the health, safety and child care communities and the families they serve.

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LEARNING OBJECTIVES

To describe the general characteristics of healthy behavior in young children from infancy to five years of age.

To identify issues underlying children's behavior problems identified in early care and education (ECE) programs.

To identify risk and protective factors contributing to behavioral health in children in ECE programs.

To identify children who are at risk of social, emotional, or behavioral health problems.

To describe three ways a Child Care Health Consultant (CCHC) can assist ECE programs with meeting the needs of children with behavioral health problems.

To identify the behavioral health resources available to assist and support ECE providers and families.

WHY IS BEHAVIORAL HEALTH IMPORTANT?

Approximately 15 million children in the United States have a behavioral health problem that affects their functioning at home and/or at school (U.S. Office of the Surgeon General, 1999). An estimated 10 to 15 percent of children under age 2 experience significant social-emotional problems (Briggs-Gowan, Carter, Skuban, & Horowitz, 2001; Roberts, Attkisson, & Rosenblatt, 1998). Children with behavior problems at an early age are at risk of developing mental health problems later in life (Broidy et al., 2003; Criss, Pettit, Bates, Dodge, & Lapp, 2002). As many as 4 out of 10 preschoolers exhibit one or more problem behaviors, such as aggression, according to teacher reports (Collins, Mascia, Kendall, Golden, Schock, & Parlakian, 2003). Young children may display their feeling, emotion, and/or problems through their behavior, thus the term behavioral health refers to children's behavior that is observable to ECE providers and parents. These behaviors may be affected by underlying emotional or social problems.

Young children with behavioral health problems place a burden on families, ECE staff, and ECE programs. Understanding the causes of these behavioral health problems, the risk and protective factors, and ways to promote positive behavioral health in young children in ECE programs is of great importance. One of the most effective ways to promote children's behavioral health is to support a warm and responsive relationship between the child and an adult. Most children's primary relationship is with a parent or close family member. ECE professionals can play an important role in supporting children's relationships with their families by developing a family-centered program. In addition, the relationship between the child and the ECE provider is also central to behavioral health.

WHAT THE CCHC NEEDS TO KNOW

What is Behavioral Health?

Children's behavioral health includes their mental and emotional health along with their social relationships. Some other terms commonly used to describe behavioral health are mental health, socio-emotional health, social and emotional wellness. The development of a child's behaviors is as important as that of his/her physical development. Infants are born with feelings and needs. They also are born with a capacity to have their needs met by communicating with and responding to their caregivers. From the start, a child's emotional development (feelings and expectations of self) and social development (feelings about and expectations of others) occur in the context of relationships with those caring for them. Shore (1997) reports that a child's relationship with his/her primary caregiver in the first few years of life lays the foundations for lifelong behavioral health.

Definitions of behaviorally healthy feelings and actions vary with children's individual development and familial/cultural characteristics. For example, biting another child might be a normal behavior for an 18-month-old, but a sign of emotional distress for a 4-year-old. Spending an extended period of time alone in the book corner may be behaviorally healthy for a child with a shy temperament and love of books, but a sign of emotional distress for a child who is usually outgoing and active. Avoiding eye contact with adults may be appropriate in a child from one culture, but a sign of abuse in a child from another culture.

Although young children exhibit a wide range of normal feelings and behaviors, Greenspan and Greenspan (1985) list some general characteristics that all behaviorally healthy young children share:

- Positive self-esteem (feeling optimistic and confident that they can make things happen).
- A capacity for warm and trusting relationships with other children and adults.
- Developmentally appropriate expression of their feelings and needs (an increasing ability to use words to express their feelings, ideas, and needs).
- Developmentally appropriate control of impulses and behavior (an increasing ability to express curiosity, assertiveness, and anger according to the norms of their particular home, culture, or ECE program).
- Initial signs of the development of empathy and compassion for others.
- Initial development of skills to focus attention and make plans as a basis for learning.

Behaviorally healthy families, like the individuals within them, also share certain characteristics. Doub and Scott (1987) identify the characteristics of behaviorally-healthy families as:

- *Adults are in charge.* They are the leaders and role models. They are respected, and they make and enforce the plans and rules.
- *Children feel they belong and are valued.* They are encouraged to participate in and contribute to family activities.
- *Communication is clear and fair.* Family members are encouraged to express how they feel and what they need. There is mutual respect among family members.
- *Changes are expected, and the family is able to respond to those changes.*
- *Outside help is sought and utilized when needed.*

ECE programs can also be viewed as a "family" where adults care for and support the learning of children. As such, well-functioning ECE programs should exhibit the characteristics of behaviorally healthy families.

Behavioral Health Development

There are short- and long-term benefits associated with a positive social and emotional development. First, quality relationships in the first years of life are critical in developing trust, empathy, compassion, generosity, and the ability to discern between right and wrong (Parlakian & Seibel, 2002). For example, when an infant cries in hunger and the caregiver promptly picks the

infant up, talks to the child sweetly, and feeds the infant, the trust that the caregiver will meet his/her needs is developed. As a toddler grows comfortable with daily ECE program routines (e.g., the caregiver's cheerful conversation during feeding, special game for diapering, or songs for naptime), the toddler learns that the caregiver will respond to his/her needs and that the toddler is worthy of love. Through a warm and responsive relationship with an adult, the child's feelings of security, trust, confidence, and well-being grow. These types of relationships serve as a buffer against stressful situations. Second, behavioral health has an impact on the child's brain development (Squires & Nickel, 2003). These experiences "affect gene function, neural connections, and the organization of the mind," having positive effects that will last a lifetime (Squires & Nickel, 2003). Third, established healthy relationships that older children have with their caregiver(s) have an impact on their cognitive development, thus acting as a factor for determining school readiness (Parlakian & Seibel, 2002).

On the other hand, a child who experiences significant maltreatment during the first few years of life is at risk for developing depression, anxiety disorders, cognitive impairment, and difficulty in relationships. Problems of this nature can be difficult to change, once established. Further, research indicates that there is a strong association between childhood mental health problems, delinquency, and future criminal behaviors (Squires & Nickel, 2003). Studies have shown that children with particular risk factors are significantly more likely to experience behavioral health problems (Shore, 1997). Although many at-risk children remain behaviorally healthy, caregivers should observe these children more closely for signs of distress and provide them with extra support. According to Shore (1997), important risk factors include:

- maternal depression or other mental illness
- poverty
- substance abuse
- homelessness
- family violence
- child abuse or neglect
- disability or other special need

Greenspan suggests that an infant's intelligence and social and emotional competence evolve over time "in the context of [his or her] relationships with parents" and other influential adults, such as regular caregivers. This model is presented in Table 1.

Why Young Children Are at Risk

Young children's early development is dependent on the strength and weaknesses of the biology of the child, the environment, and parents' psychosocial circumstances during the first years of life.

Just as the dramatic brain development during the first five years creates the patterns for learning that last a lifetime, so do the emotional and social environments establish the relationship patterns and social and emotional growth that affect a child's behavioral health. If the environment does not provide the support the child requires, behavioral health problems may result. The following child and environment factors significantly influence young children's behavioral health in the first five years of life:

- overall physical health of the child
- neurodevelopment characteristics and temperament
- family stressors and resources available to provide support
- developmental opportunities for growth and intervention when needed
- community stressors and resources
- child-caregiver relationships
- goodness of fit of parental expectations
- parental capacity to cope, and emotional availability
- parental self-esteem
- capacity to provide protection from over stimulation
- internal family harmony
- social supports

TABLE 1: GREENSPAN'S SIX ESSENTIAL DEVELOPMENTAL STAGES (FROM PARLAKIAN & SEIBEL, 2002)		
Developmental Goal	**Age Range**	**What's Happening?**
Stage 1 Being calm and interested in all the sensations of the world.	Birth to 3 months	The baby is: • Learning how to be calm, regulated, secure, and interested in the world around him/her • Trying to organize the information he/she is receiving from his/her senses
Stage 2 Falling in love	Begins at 2-4 months, roughly spanning the period from "first smiles" to "crawling"	The baby is: • Becoming more focused on parents and other people and things outside of him/herself • Expressing emotional reactions of his/her own (e.g., smiles and frowns) • Expressing pleasure in other's company
Stage 3 Becoming an intentional two-way communicator	3-10 months	The baby is: • Purposefully using gestures (facial expressions, actions, sounds) to communicate • Responding to others' gestures with gestures of his/her own • Realizing that his/her expressions elicit a response from parents and caregivers and that what he/she expresses can and does have an effect
Stage 4 Learning to interact to solve problems and discover a sense of self	9-18 months	The baby is: • Learning to solve problems • Learning to see and decipher patterns • Communicating in increasingly complex ways • Learning what to expect from others, based on interactions and experiences with parents and caregivers
Stage 5 Creating ideas	16-36 months	The child is: • Becoming skilled in symbolic thought (e.g., labeling images with words) • Using verbal means to communicate needs and desires • Engaging in pretend play • Learning to recognize and communicate his/her feelings • Learning to understand others' feelings
Stage 6 Building bridges between ideas	36-48 months	The child is: • Sharing his/her own ideas; exchanging ideas with parents and caregivers • Learning to be logical, connecting one ideas to another in a meaningful way • Developing a sense of time • Developing a sense of space, or "near" and "far" • Making connections between ideas that convey feelings (e.g., asking "Why are you sad?")

Issues that Arise in ECE Programs

Behavior Is Communication

All behavior is a tool of communication for the young child. Young children who are preverbal have few tools to communicate with, and thus, communicate most often by crying for help and averting their eyes. Even children ages 2-5 years old may not yet have the verbal skills to tell ECE providers and parents what is happening in their life, so they may communicate their feelings through their behavior. Their general behavior, play, social interaction and relationships with peers and adults can tell us a great deal. In order to assist the ECE professional in meeting the needs of a particular child, objective observation skills are a necessity. According to Poulsen (1996), children communicate stress through the following types of behavior:

- overactivity
- inability to focus on or complete a task
- becoming easily frustrated
- inability to make decisions
- inability to follow directions
- increased aggressive behavior such as hitting, biting, grabbing, pushing
- tantrums
- excessive clinginess to adults
- avoidance of new challenges
- avoidance of peers
- frequent crying
- refusal to eat

Behavioral Health Problems Do Not Equate Mental Illness

Identifying a child as being at risk of behavioral health problems does not mean he or she is mentally ill. There is a difference between being at risk and being diagnosed with a mental illness. If a child is at risk, it may simply mean the child needs help to build the resilience needed to counterbalance their vulnerability (Poulsen, 1996). The child may need support to develop the internal resources that allow him or her to cope, or the child may need different environmental supports.

Causes Can Suggest Solutions

Identifying possible causes of a behavior problem can be helpful in finding solutions. Children's challenging behaviors in ECE programs may be caused by many complex factors. Some of the common factors are: developmental stage, individual differences (i.e., temperament), the environment, or unmet emotional needs. Understanding the purpose of the child's behavior is essential to working with the child to eliminate the behavior. See Table 2 for an overview of possible causes of behavior and possible actions ECE providers and CCHCs can take.

Diagnosis of Children

Parents and ECE professionals want to avoid labeling children and may be very resistant to attempts to label a child. CCHCs and ECE professionals cannot diagnose the behavior problem; they can only determine the behavioral indicators via interviews with parents and observations of the child. If it is determined that assessment is needed, observational information, with parental permission, can be communicated to the health care professional conducting the assessment and diagnosis.

Hyperactivity

Many risk factors can lead to behaviors that look like biologically based hyperactivity, but can be caused by numerous other sources. CCHCs can advocate for very careful, mindful consideration before any medication is administered (see *Handout: Health and Safety Note: Understanding and Caring for Children with ADHD*).

Disabilities and Other Special Needs

Challenging behaviors can be a sign of other disabilities and special needs. For example, a child who is always yelling, frustrates easily, and is inattentive when adults or peers talk to her may have a severe hearing loss.

TABLE 2: TOWARD A BETTER UNDERSTANDING OF CHILDREN'S BEHAVIOR: POSSIBLE CAUSES OF BEHAVIOR PROBLEMS AND ACTIONS (adapted from the Program for Infant/Toddler Caregivers (PITC) Training Manual Module I, Johnston & Thompson)

First Possible Cause: Developmental Stage		
Why is this happening?	**What are the clues?**	**What actions should ECE providers take?**
The behavior is a usual part of development and is due to the child's developmental stage. The child is mastering a new developmental skill and is practicing this new skill.	• Other children at the same developmental stage behave this way. • Research on child development supports the behavior.	**Relax**. All children behave this way. The behavior will change with development. **Channel**. Allow the behavior in certain situations and at certain times (as long as no harm is being done to others or to the child) **Stop**. Stop the behavior when it is disruptive or dangerous.

Second Possible Cause: Individual Differences		
Why is this happening?	**What are the clues?**	**What actions should ECE providers take?**
Temperament or constitutional qualities account for differences in behavior. All children experience the world differently based in part on their temperament. Not all children of a certain age act in exactly the same ways.	• Not due solely to developmental stage. • Observations of the child in the ECE program, and parental report about the child's behavior at home both provide information about the child's temperament. • Research on temperament supports this behavior.	**Observe.** Observe and identify each child's unique style. **Adapt.** Adapt your expectations and interactions with this child based on temperamental characteristics. **Give choices**. When possible, offer options that allow for and appreciate children's unique expressions and responses to the world. **Communicate**. Ask parents for possible explanations and solutions.

Third Possible Cause: The Environment		
Why is this happening?	**What are the clues?**	**What actions should ECE providers take?**
The behavior is due to the environment or to conflict between different environments the child spends time in. Environments might include: ECE setting Home setting Family routines Family lifestyle Cultural context	• Behavior is not due to developmental stage or to individual differences. • In the ECE setting, several children are exhibiting similar behaviors. • There are different expectations of the child in the home and ECE programs. • The child is responding to changes in the home environment and showing sudden change in behavior at home.	**Change**. If the child is responding to something specific in the ECE setting, change the environment to help the child feel in control. **Adapt.** Adapt your expectations to reduce conflict. **Communicate.** Ask parents about the characteristics of the other environments the child spends time in. Ask parents for possible explanations and solutions.

Fourth Possible Cause: The Child Does Not Know But is Ready to Learn		
Why is this happening?	**What are the clues?**	**What actions should ECE providers take?**
The child does not know something but is ready to learn. It may take time for a child to understand, internalize, and master new social expectations and rules.	• Behavior is not due to development, individual differences, or the environment. • The child is in a new or unfamiliar situation. • The child is facing a new task or problem.	**Teach**. Teach a new skill, rule, or expectation, and explain it repeatedly. Give reasons for the new rule. **Encourage**. Give encouragement for small successes. **Help**. Offer help and be patient with failures.

Fifth Possible Cause: Unmet Emotional Need		
Why is this happening?	**What are the clues?**	**What actions should ECE providers take?**
The child may have missed out on some part of development that was emotionally important. The child may be searching for new ways to meet this need.	• The behavior is developmentally inappropriate (child is not acting his age). • The behavior is consistent across time and context. • The behavior has a persistent, excessive quality as if the child has little control over the behavior. • The usual ways of handling and helping most children with this behavior do not seem to be helping.	**Respond**. Respond to the child's needs actively with deeds, and support. **Be firm.** Meet the child's needs with quiet firmness and patience. **Control.** Remember that the child cannot stop or control the behavior. **Seek help.** Get additional support for yourself, the child, and the family.

ECE Environments and Challenging Behavior

Challenging behaviors can be the result of the ECE environment, and not the home environment or parenting of the child. CCHCs can look for patterns of behavior in the group setting that may indicate a need for adjusting the ECE environment. An example of this may be that many children are very aggressive, lack impulse control, and are easily upset each day at noon when they are outside playing. They may be hungry and irritable at that hour, and simply serving lunch a bit earlier could change the environment.

Common Behavior Problems Versus More Serious Problems

A behavior management plan can help differentiate between common behavioral problems that can be managed through early childhood positive guidance techniques (Kaiser & Raminsky, 1999), and those behavioral problems that are more serious for which a referral to an early childhood mental health consultant may be needed. Positive guidance is a discipline technique that emphasizes promoting the child's feelings of being lovable and capable; it focuses on telling children what they can do rather than what they cannot do.

Parental Mental Health Problems and Children's Development and Behavior

Parental mental illness can compromise parenting and negatively impact a child's development. Depressed mothers tend to be less responsive to their young children, show less affection, and less positive emotional interaction. If parental depression is not identified and treated, children may be at risk of developing behavioral health problems. If an ECE program is concerned about the mental health of a parent, a referral to a public health nurse can be made for the family.

Challenges for Children and Families in ECE Programs

- When a young child enters an ECE program for the first time, the parent-child relationship is interrupted. If the child does not have an emotionally secure attachment with at least one significant adult, the entrance to an ECE program may amplify the struggle to establish secure relations for the child. The parent's response to placing her child in an ECE program can also amplify attachment issues.
- If the parent feels that she is "giving up" her child rather than establishing a partnership with the ECE provider, the parent-child attachment may change and this change could trigger an increased risk for behavioral problems. Parents with low self-esteem may have difficulty accepting the ECE provider's role as caregiver and may feel threatened by the situation.
- Policies that support gradual transitions into new ECE programs and healthy adjustment to group care may not exist. As a result, children may show their emotional response via negative behaviors such as withdrawal, aggression, defiance, and inconsolable crying, depending on the developmental age of the child. Creating a sound policy of gradual transition into ECE programs can greatly reduce the negative impact for parents and children by allowing time for the needed confidence and trust in one another to develop. The parent needs to feel confident in the ECE provider's skills and abilities, and the child must feel connected to the ECE provider in order for the transition to be a smooth one.
- ECE providers may not have sufficient training in identifying and responding to risk factors nor accessing resources to support children's behavioral health. Although ECE providers may be very cognizant of developmental milestones, they may accept a broader range of behavior before seeking outside support. They may also hesitate to communicate their concerns about a child to his or her parents. As a result, some children may not receive the support they need until they are in danger of being removed from an ECE program. The challenge is to intervene before the ECE provider has reached the extent of his or her ability to care for that child.
- Once children and their families are identified as at risk, there are often insufficient services available to meet their needs, especially for children under 5 years of age. Many mental health providers and community mental health services do not

have the capacity to provide services that include the family with children under 5 year of age or to an individual child under 5. In addition, the mental health system seldom allocates sufficient resources for prevention, focusing instead on the seriously mentally ill. Young children do not usually exhibit serious mental illness, but some are at risk of developing serious problems later in life.

What is Resiliency?

Resiliency is the ability to recover readily or bounce back from stressful life experiences. For example, when children experience a stressor, such as parental divorce, some children's behavioral health and development will be more adversely affected than others. Werner (1990) reports that children who are resilient in the face of adversity tend to have certain protective factors present in their life history. Protective factors moderate or buffer the negative effects of stress resulting in more positive outcomes in at-risk children than would have been expected (Masten & Garmezy, 1985). Garmezy (1985) suggests that protective factors can be divided into three categories:

- child attributes (e.g., adaptive, positive temperament characteristics)
- supportive family environment (e.g., positive parent-child relationship)
- community support systems (e.g., quality ECE programs)

Child Attributes as Protective Factors: Temperament and Goodness of Fit

Temperament is the natural, inborn style of behavior of each individual (Carey & McDevitt, 1995). It is a combination of inborn traits and personal experience that shapes our perception of and response to the world around us. It is the "how" of behavior, not the "why." (See *Handout: Health and Safety Notes: Temperament and Regularity*.) It is important to understand how children's individual temperamental traits influence their behavior. Some temperamental characteristics buffer children from adversity and other characteristics may make children more vulnerable to stress. In addition, the fit between a parent or caregiver's temperament and the child's temperament also influences behavioral health outcomes. (See *Handout: Temperament and Goodness of Fit.*)

The ECE provider closely observes the child every day and becomes very familiar with the child's temperament. While children's development generally proceeds through predictable patterns, each child charts a unique path through the stages of development of behaviors and skills. In addition, each child has a unique temperament or style of responding to the world. For example, some babies love being free to kick and feel the air on their skin while others get agitated if they are not tightly swaddled; some preschoolers can sit and draw with crayons for an hour while others can sit quietly for only 10 minutes before jumping up and running around.

Understanding a child's temperament can help a provider structure the ECE program (the relationships, environment, and activities) to best meet each child's needs. There is no good or bad temperament. In fact, studies show that the temperament traits that caregivers consider to be easy vary among cultures. When caregivers routinely document their observations and share them with parents, it can help both the caregiver and parents understand the child better. (See *Handout: Temperament and Behavior*.)

The following are types of temperamental characteristics that can be protective factors for children (adapted from Rothbart, Derryberry, & Hershey, 2000):

- *Low to Medium Distractibility.* Can concentrate and pay attention for long periods of time; listens well.
- *Low to Medium Intensity.* Expresses emotions (positive and negative) with moderate intensity.
- *Regular/Predictable.* Regular schedule in terms of feeding, sleeping. Always gets hungry at the same time of day.
- *Moderate to High Sensory Threshold*. Not easily overstimulated. Can tolerate loud noises.
- *Adaptable.* Has little difficulty with changes and transitions. Adapts well to new foods and routines.
- *Positive Mood.* Generally a happy child; rarely cranky.

Relationships as Protective Factors

Lally (1990) reports that the most effective way to promote children's behavioral health is to support a warm and responsive relationship between the child and an adult. Most children's primary relationship is with a parent or close family member. ECE professionals can play an important role in supporting children's relationships with their families by developing a family-centered program. Children and families learn that their relationships are valued when, for example, providers:

- inquire about the child's and family's history during enrollment;
- ask families to post photos on their child's cubby;
- invite parents to teach the children about their families favorite foods and songs;
- tell parents each day about the special things their child did; and
- offer families developmental guidance and support.

For young children in ECE programs, a close relationship with a teacher or other caregiver is crucial. ECE programs can promote such attachments by maintaining adequate adult:child ratios, small group sizes, assigning children a primary caregiver, and maintaining the continuity with that caregiver over the time the child attends the program. Studies show that young children, especially infants and toddlers, who have a close relationship with a caregiver in their ECE program demonstrate better social and emotional skills. A close relationship with a caregiver can also be a lifeline for children who lack a strong relationship within the family, e.g., through abuse or neglect (Lally, 1990).

Warm, responsive relationships are built on understanding. To develop a close relationship, ECE providers must get to know each child (his/her development, temperament, likes and dislikes, and past experiences) and work to meet the child's particular needs. When the partners in a relationship feel understood and successful with each other, the relationship grows strong.

ECE providers should use parents as a bridge and a guide to understand and build a relationship with the child. For example, the more a provider knows in advance about what the child likes to eat and how the child gets put down for a nap, the more effective s/he can be from the very beginning in making the child feel safe and loved. On an ongoing basis, the more frequently the ECE provider discusses with parents their child's health issues, the better s/he can prevent or respond promptly to the child's illnesses and help the child feel healthy and safe in the ECE program.

Quality ECE Programs as Protective Factors

ECE programs can function as vital community support systems to families of young children. Quality ECE programs can act as a protective factor for children at risk by providing responsive care, secure attachment by a primary caregiver, and safe, predictable routines. Additionally quality ECE programs offer parent support and education services that may strengthen families and connections to the community.

To support children's resiliency, ECE professionals should insure that:

- each child has a caring relationship with at least one adult
- each child has opportunities for meaningful participation
- they have high expectations for each child and believe that each child can make a contribution
- each child's abilities are recognized

Identifying Children with Behavioral Health Problems

It is appropriate to seek mental health consultation and support if a child's behavior is causing prolonged distress for parents, caregiver, and/or the child. Behavior problems that persist over a period of time and in different contexts (i.e., at home and in the ECE program), often despite negative consequences, often require intervention from mental health professionals.

A child who displays a troubling behavior only once or twice, such as a 4-year-old who punches a classmate in the absence of other risk factors or "red flags" is probably not a concern. If the child punches classmates frequently despite assistance with using words to express his/her feelings or time-outs for unacceptable behavior, the ECE provider should take action. Mental health consultation and/or intervention offers support not only with severe mental health problems (e.g., post-traumatic stress disorder, depression, severe emotional disturbance), but also with common developmental experiences that can be stressful for children, parents, and ECE providers (e.g., infants not sleeping through the night, toddlers having difficulties with toilet learning, and preschoolers being very active).

Behavioral Warning Signs

ECE providers should be able to identify behaviors which are "red flags" or warning signs that indicate social and emotional difficulties. Experienced caregivers report that they have a sixth sense for identifying children with behavioral health problems because these children provoke uncomfortable feelings in others. Their behavior is often characterized as:

- emotionally extreme (extreme anger or sadness)
- inappropriate for their age/developmental stage
- hurtful to themselves or others
- difficult in that others have trouble forming positive relationships with them
- driven, excessive, persistent or out-of-control

The following behaviors indicate that an infant or toddler's behavioral health may be at risk:

- displays very little emotion
- does not show interest in sights, sounds, or touch
- rejects or avoids being touched or held
- unusually difficult to soothe or console
- unable to comfort or calm self
- extremely fearful or on-guard
- exhibits sudden behavior changes

The following behaviors indicate that preschool age child's behavioral health may be at risk:

- cannot play with others or objects
- absence of language or communication
- frequently fights with others
- very sad
- extreme mood swings
- unusually fearful
- loss of earlier skills (e.g., toileting, language, motor)
- sudden behavior changes
- destructive to self and others

Based largely on his/her assessment of the quality of the behaviors, the ECE provider must determine whether a child's behavior is part of normal development or a warning sign for social and emotional difficulties.

To assess quality of behavior, the ECE provider must observe the child closely and decide:

- whether the behavior appears casual and pleasurable for the child or it is driven, excessive, out-of-control or has an unpleasant quality to it; and/or
- whether the child is otherwise healthy and well-adjusted, or has other behaviors or risk factors that raise concern.

Assessing Children's Behavior and Development

Meeting the needs of children with behavioral health problems can be challenging. It is critical for ECE providers to know when and how to seek additional information and help from the family, colleagues, supervisors, and mental health specialists.

To confirm concerns about children with behavioral health problems, the ECE provider should:

- observe and document the child's behavior over time and in a range of different relationships, environments, and activities over the course of

several days (identify how often the behavior occurs, when, where, and with whom, and what happens as a result of the behavior)

- obtain information from the family about the child's prenatal and birth history, medical conditions, development, temperament, likes and dislikes, family relationships, previous ECE program experiences, and behavior at home
- have a co-worker or supervisor observe the child to provide a different perspective and/or independent confirmation of the problem behavior
- calmly, objectively, and briefly summarize concerns about the child's behavior when meeting with the parents and then work together with them to understand the behavior and develop strategies to better meet the child's needs
- with parental consent, request that a mental health consultant observe and assess the child and provide consultation on strategies for intervention.

Developmental screening is an important component of behavioral health assessment (Zeanah, Stafford, Nagle, & Rice, 2005). See Table 3 for a list of standardized screening tools which can be helpful in monitoring development or identifying behavioral health problems. Developmental screening tools are meant to identify whether or not there is a significant problem needing further diagnostic assessment. Developmental screening tools are not diagnostic, rather they inform parents and ECE professionals whether a problem exists, and whether to seek additional information and support.

Children's Mental Health Services

CCHCs can help ECE providers understand when children and their families might need mental health consultation. It is important to know the role mental health consultants play as well as who they are. In addition, it is helpful to be aware of funding sources for mental health services.

Who Are Early Childhood Mental Health Consultants?

ECE programs can work with early childhood mental health consultants in a variety of ways depending on the program's mental health needs (i.e., those of the children, families, and ECE professionals), the program's priorities, and its available resources. Early childhood mental health consultants have training and experience in both mental health and child development. They may come from a variety of professional backgrounds including licensed clinical social worker; marriage, family, and child therapist; clinical psychologist; psychiatrist; or developmental pediatrician. They may have different approaches to working with children based on their professional background and their assessment of the needs of the situation.

What Do Early Childhood Mental Health Consultants Do?

On-site mental health consultants provide a broad range of preventive and therapeutic services. They work with children, families, and ECE professionals as individuals (i.e., an individual child, a parent, or a teacher) and/or in groups (i.e., groups of children, parents, or teachers). Examples of ECE mental health consultation services include:

- observations of a child in the classroom
- assessments of a single child
- individual therapy with a child
- therapy with parents/families
- therapeutic play groups for children
- education and support groups for parents
- consultation, education, and support for teachers
- consultation for directors
- referral of children and families to services

On-site mental health consultation also helps promote early identification and intervention for social and emotional difficulties, thereby reducing more serious mental health problems. In addition, the on-site consultant has the opportunity to observe, assess, and provide therapeutic interventions for children

TABLE 3. SOCIAL-EMOTIONAL DEVELOPMENTAL SCREENING INSTRUMENTS FOR CHILDREN LESS THAN 6 YEARS OF AGE

Screening Tool	Ages	Completed by whom?	# Items /Format	What does it tell us?	Languages available?	Reference and/or Web site
The Ages and Stages Questionnaire: Social-Emotional (ASQ-SE)	6-60 months	Parent or Teacher	30	• Recognizes young children at risk for social or emotional difficulties • Identifies behaviors of concern to caregivers • Identifies need for further assessment	English and Spanish	Squires, Bricker, & Twombley (2002) www.pbrookes.com/store/books/squires-asqse/index.htm
The Child Behavior Checklist, Early Childhood Inventory	1 ½ - 5 Years	Parent or Teacher (Caregiver-Teacher Report Form C-TRF)	99	• Assesses externalizing and internalizing behaviors • Gives clinical cutoff scores	English and Spanish	Achenbach, & Rescorla (2000) www.aseba.org/products/cbcl1-5.html
Devereux Early Childhood Assessment Program (DECA)	2-5 yrs	Parent or Teacher	Frequency of 27 positive behaviors; 10 item Behavioral Concerns Scale	Identifies children who may be experiencing emotional/behavioral problems	English	LeBuffe & Naglieri (1999) Kaplan Press
PEDS (Parents' Evaluation of Developmental Status)	Birth to 8 years	Parent	10 items	Determines when to refer, provide a second screen, provide patient education, or monitor development	English, Spanish, and Vietnamese	Glascoe (1997) www.pedstest.com/index.html
Brief Infant/Toddler Social Emotional Assessment (BITSEA)	12-36 months	Parent or Caregiver	42 items	Identifies social-emotional/behavioral problems and delays in social competence	English	Briggs-Gowan, M., Carter, A. S., Irwin, J. R., Wachtel, K. & Cicchetti, D. V. (2004)
Vineland Social-Emotional Early Childhood (SEEC) Scales	Birth to 5 years, 11 months	Parent or Caregiver	Interview takes 15-20 minutes	Identifies strengths and weaknesses in specific areas of social-emotional behavior including interpersonal relationships, play and leisure time, and coping skills	English	Sparrow, Balla, & Cicchetti (1998) Published by American Guidance Service, www.agsnet.com
Brigance Infant and Toddler Screen	Birth to 2 years	Parent	Interview takes 10-15 minutes	Identifies infants and toddlers in need of further diagnostic testing or special services	English and Spanish	Curriculum Associates www.curriculumassociates.com
Eyberg Child Behavior Inventory (ECBI)	2-16 years	Parent or Caregiver	36 items	A cutoff score is given suggesting the presence of disruptive behavior problems	English	Eyberg & Pincus (1999) Psychological Assessment Resources www.parinc.com

within the ECE program, in the context of their daily activities, and through their relationships with their caregivers, family members, and other children. This helps insure that the mental health services apply directly to the child's daily life. Mental health consultation can increase the overall quality of ECE programs and improve ECE staff's ability to work with children with challenging behaviors (Alkon, Ramler, & MacLennan, 2004).

Referral to an early childhood mental health consultant may be indicated if:

- a child does not respond to behavior management plans
- a child's behavior problems escalate and /or staff becomes increasingly frustrated
- a child has repeatedly injured other children or adults
- a child has repeatedly destroyed property
- a child has difficulty playing with other children or relating to adults

Funding for Mental Health Services

In 1992, Congress created the Center for Mental Health Services (CMHS) under the ADAMHA Reorganization Act, P.L. 102-321, which amended research and service programs for alcohol, drug abuse, and mental health. At the time, CMHS became the federal leader in delivering mental health services to adults and children, generating and applying new knowledge about mental health, and establishing national mental health policy. CMHS works in partnership with state and local mental health authorities, service providers, consumers, and families of consumers on quality assurance and increasing the accessibility mental health services for those in need, including children. CMHS is a division the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). The Center for Mental Health Services houses The Child, Adolescent and Family Branch. This program promotes and ensures that the mental health needs of children and their families are met within the context of community-based systems of care.

Public sources of funding for direct mental health services to children and their families include:

California State Child Health and Disability Prevention (CHDP) (a.k.a. EPSDT: Early and Periodic Screening, Diagnosis, and Treatment)

These preventive health care services for income eligible children under 21 years of age include behavioral health assessment. If the health care or mental health professionals agree that additional services are needed, the following services will be provided: individual therapy, group therapy, family therapy, crises counseling, case management, special day programs, medication for mental health. Services may be provided in the home or in the ECE program. A brochure explaining the benefits can be obtained from www.dhs.ca.gov/publications/forms/pdf/mc003info.pdf, and a directory of local CHDP offices can be found at www.dhs.ca.gov/org/pcfh/cms/chdp/directory.htm.

California Work Opportunity and Responsibility to Kids (CalWORKs)

CalWORKs is a welfare program that gives cash aid and services to eligible needy California families. The program serves all 58 counties in the state and is operated locally by county welfare departments. Participants are eligible to receive help with medical and child care expenses. Additionally all 58 counties offer some supportive services which may include mental health counseling, domestic violence assistance, and substance abuse treatment. Participants in need of these services should consult with or be referred to their CalWORKs' case manager.

Local Education Authority

Young children identified as "at risk" and those exhibiting signs of educational disabilities can be referred to the Local Educational Authority (usually the public school district) for assessment under P.L. 99-457. Mental health services are available through Special Education Services if assessment leads to a diagnosed disability (e.g., Serious Emotional Disturbance). Identified needs are served under the Individualized Family Service Plan for birth to 2-year-olds or under the Individualized Education Plan for 3 to 5-year-olds.

Head Start

Children who are in Head Start also may qualify for mental health services through Head Start Health or Disabilities Services.

Additional publicly funded mental health services may be available through Community Mental Health Services at the local Department of Health and at community clinics. In most communities, however, these services focus on treating individuals with psychiatric diagnoses and have limited services available for children with emotional and behavioral difficulties. ECE programs can also collaborate with local early childhood mental health services to obtain grants to fund mental health services in their settings. Local First 5 commissions have made mental health services to young children and families a priority.

WHAT THE CCHC NEEDS TO DO

Observe the Program

CCHCs can observe the ECE program to determine if the environment supports children's behavioral needs. Is the environment warm and welcoming? Is the schedule of the day structured? How are transitions between activities handled? Do the children seem happy? Are the adults in charge? Do children feel they belong and are valued?

Review Policies and Procedures Related to Behavioral Health

The CCHC can assess whether there are consistent methods for observing and documenting children's behavior. If there are no procedures in place, the CCHC can work with the ECE provider to develop a consistent method for observing and documenting information about behavioral concerns and difficulties, and for sharing this information with parents. See *Handout: Behavioral Data Collection Shee*t and *Handout: Special Care Plan for a Child with Behavior Problems*, developed by ECELS, to help with documentation. Assist the ECE provider in developing policies about when and how to seek professional mental health consultation and how to implement it. Assist the ECE provider in learning how to interpret problem behavior and in developing strategies for responding appropriately to it. This may require adaptation of the ECE environment to reduce distractions and/or eliminate other trouble spots.

Educate ECE Providers, Parents, and Children About Behavioral Health

The CCHC can encourage ECE providers and family members to be aware of the characteristics of behaviorally healthy children and families. To the extent that an ECE provider can be viewed as an extension of the child's family, it is part of the CCHC's responsibility to insure that the provider reflects the characteristics of behaviorally healthy families as outlined above. The CCHC can insure that the ECE provider understands the importance of a family-centered program, how to build a strong caregiver-child relationship, and how to support children's resiliency. The CCHC can help the ECE programs develop specific plans and procedures to achieve these goals. The CCHC can provide information about different temperament characteristics and about the goodness of fit principle. Ensure that the ECE staff are aware of important environmental and physiological risk factors and behavioral indicators for social and emotional difficulties.

Learn About Positive Guidance Techniques Used by ECE Professionals

The ECE field has developed many resources related to positive guidance, otherwise known as discipline. Using positive guidance as a discipline tool, children develop self-control through understanding rather than punishment (Kaiser & Rasminsky, 1999). The National Association for the Education of Young Children (NAEYC) has resources about these techniques on their Web site (www.naeyc.org).

Provide Resources

Create a list of local behavioral health services and community resources that would be useful to ECE programs. The list should include information regarding eligibility criteria, hours of operation, types of services available (e.g., on-site and/or office-based), fees, and insurance coverage. All services should be contacted once a year to update information.

Build Relationships with ECE Providers

The CCHC's ability to build a trusting relationship with ECE providers can lead to an open and communicative relationship within which a supportive dialogue can take place. It is this dialogue about the child that leads to an action plan which can most benefit the child, the family and the ECE professional.

Assist ECE Professionals with Problem Solving

Provide an opportunity for ECE staff to establish what all of the contributing issues are, dialogue around possible action, and evaluate their action. Developing your listening, observation and facilitation skills can assist in supporting ECE providers' efforts to find their own solutions. You can also facilitate the discussion by completing an objective observation of the child prior to the meeting with the providers and communicating what you saw to further their knowledge and yours as to what may be happening.

Link Programs with Community and Professional Resources

The CCHC should be familiar with the services and resources available to families with behavioral health concerns. The CCHC can network with community groups (e.g., child advocacy groups, church groups, civic groups) to reinforce a positive attitude towards child behavioral health needs and resources. The CCHC can establish a relationship with the county Children's Mental or Behavioral Health Department to demonstrate the need for prevention services for children in ECE programs. In addition, the CCHC can assist the ECE professional by researching the funding resources (e.g., Community Mental Health Services, Civitas, Junior League, child advocacy groups) and granting agencies (e. g., United Way) available in the community that might help with financing assessment and treatment for children's emotional and behavioral difficulties.

Be Knowledgeable About Current Mental Health Issues Related to Children and ECE

This includes reading newspapers, magazine articles, journals, and studies on child mental health issues, as well as networking with community and state organizations and agencies to keep informed of local and national mental health trends and/or treatments.

WAYS TO WORK WITH CCHAs

The Child Care Health Advocate (CCHA) is in the ECE program every day, and can observe the child over time and at different times of the day and week. Their role includes working closely with the ECE staff to identify those children whose behavior and/or health are of concern, to discuss needed action, and to communicate concerns to the CCHC. In addition, the CCHA can facilitate the dialogue with staff, needed meetings with parents, and follow-up activities. The CCHC can ensure that the CCHA has the resources needed to communicate effectively with ECE staff and families.

ACTIVITY 1: TAKING A DIFFERENT PERSPECTIVE

Using the CCHC Problem Solving Process (Seattle-Kings County Department of Public Health, 1994), discuss how to assess, plan, implement and evaluate a solution to the ECE provider's problem described in the scenarios below.

The CCHC Problem Solving Process

1. Define the behavior (problem): Have the child (or children) tell you what the problem is in their words if they can. Or you may explain to the child what you think the problem is in your words. Have the ECE staff describe what they believe is the problem behavior. (Who owns the problem, the adults or child?).
2. Gather information: When, where, and why does this behavior occur? Track the behavior over a period of three days. (See Handout: Behavior Data Collection Sheet.) Review other sources of information: parent's health history, developmental assessments, teacher and parent reports.
3. Formulate a hypothesis: Why is this behavior occurring?
4. Create ideas: In collaboration with staff and parents, come up with several ways for solving the problem. Use resources (e.g., positive guidance information, temperament information, and adapting the environment). Ask the child for solutions if old enough.
5. Communicate the plan: Select the ideas with agreement from caregivers and parents and child if old enough. Make sure everyone knows what the plan is and who is responsible for doing what actions.
6. Try it: Give it an amount of time with a clear beginning and ending date.
7. Evaluation: Decide if the plan worked. Plan next steps. Know when an outside referral for an early childhood mental health professional is needed.

James' Story

James is a 4-year-old in an ECE program. He is living with his grandmother while his mother attends a residential drug treatment program.

James is very active. He likes to ride his tricycle, and he loves superheroes, especially Batman. Sometimes he wears his grandmother's black slip to school that he calls his "Batman cape." Then he "flies" around the classroom knocking down everything in his path. Once he knocked down a girl with such force that she had to get stitches on her forehead.

It's not easy to predict James' behavior. He has scratched and bitten other children a number of times. And just last week, in the middle of circle time, he pulled down his pants and urinated on his carpet square. When asked why he did it, James said, "Batman told me to."

Read the perspectives on James' story. Imagine that these are the perspectives of different teachers and specialists caring for James.

Perspectives on James' Story

Perspective #1

"James can be really wild and unpredictable. He has a hard time following directions, and transitions are hard for him. Once we went on a field trip to the zoo, and he just cried and cried. I tried to comfort him, but he wouldn't let me touch him. Once I tried to hug him, and he hit me. It's pretty obvious that James is a crack baby. There's nothing our ECE program can do for him— the damage has already been done."

Perspective #2

"I really try to be understanding, but James just tests my patience every step of the way. It's almost like he wakes up in the morning and figures out the best way to get to me. Last week was the worst! My supervisor came to observe me, and I was just praying that James would be on his best behavior. I even took away his "cape" that morning so he wouldn't pull one of his Batman stunts. He didn't. Instead, he pulled down his pants and urinated right in the middle of circle time! I was so embarrassed. What will he do to me next?"

Perspective #3

"That boy needs something to calm him down. I heard that Ritalin can work wonders. Maybe if he took that, he wouldn't be such a wild man."

Perspective #4

"I'm starting to think that James' behavior has something to do with me. I've watched him with one of the specialists, and he's a different kid with her. When he's with her, he's calm, he listens, and he laughs. He never hits other kids when she's around. For some reason, I just can't seem to give him what he needs."

Perspective #5

"The teacher asked me to watch James, especially during circle time. He does okay at first. But after 20 minutes, he starts getting really "antsy." Yesterday he started squirming. Then he pulled someone's hair. Then he started flying around the room. I realize that James does have some trouble managing his behavior. But why should any child be asked to sit that long? Many 4-year-olds would act out after 20 minutes. It's the classroom that needs to change."

Perspective #6

"James has a great imagination. Sometimes we play with the 'guys,' the action figures that he always carries in his pocket. He makes up wild scenes where the bad guys devise elaborate and wicked plans. Sometimes in his play, he talks about being lost. More and more I see him as a really scared little boy. I don't think he feels truly safe anywhere: at school, at home, or even inside his own head."

From Sokal-Gutierrez, et al., 2004.

ACTIVITY 2: GOALS AT AGE 3 OR 4

Fill in the blanks on *Handout: Goals for the Emotionally Healthy Child at Age Three or Four*. Discuss how these goals may impact school readiness.

ACTIVITY 3: TEMPERAMENT TREASURE HUNT

Fill in the blanks on *Handout: Temperament Treasure Hunt* by walking around the room and talking to one person at a time. Find someone who fits each of the descriptions. Each name can only be used once.

ACTIVITY 4: UNDERSTANDING A CHILD'S BEHAVIOR

Identify a child you have cared for and describe the child's challenging behavior on the *Handout: Understanding a Child's Behavior*. Discuss possible causes of the behaviors described using Table 2 in the curriculum: Toward a better understanding of children's behavior.

NATIONAL STANDARDS

From *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, Second Edition*

1.041	Knowledge and Skills of Child Care Health Consultant
2.054	Parent's Information on Their Child's Health and Behavior
2.056	Community Human Service Resources Information
2.067	Parent Education Plan
8.015	Identification of Child's Medical Home and Parental Consent for Information Exchange
8.075	Community Resources Information
9.033	Support for Consultants to Provide Technical Assistance to Facilities
9.041	Technical Assistance to Address Diversity in the Community

CALIFORNIA REGULATIONS

From *Manual of Policies and Procedures for Community Care Licensing Division*

101218.1	Admission Procedures and Parental and Authorized Representatives Rights
101223	Personal Rights
101226.3	Observation of the Child

RESOURCES

Organizations and Resources	
Organization and Contact Information	**Description of Resources**
American Academy of Pediatrics (AAP) National Headquarters: 141 Northwest Point Boulevard Elk Grove Village, IL 60007-1098 (847) 434-4000 phone (847) 434-8000 fax www.aap.org	Professional association of pediatricians dedicates its efforts and resources to attain optimal physical, mental and social health and well being for all infants, children, adolescents and young adults. The Behavioral and Mental Health Web pages address child and family emotional well-being and coping. Look here for information on raising emotionally healthy children and coping with common behavioral and mental health conditions and stressful life situations. www.aap.org/healthtopics/behavmenthlth.cfm Since December 1989, the Pennsylvania (PA) Chapter of the American Academy of Pediatrics (PA AAP) has operated the Early Childhood Education Linkage System (ECELS). Now operating Healthy Child Care Pennsylvania, ECELS provides health professional consultation, training, and technical assistance to improve early childhood education programs in the Commonwealth. www.ecels-healthychildcarepa.org. Bright Futures http://brightfutures.aap.org/web/familiesandcommunitiestoolsandresources.asp
Center on Infant Mental Health and Development University of Washington Center on Human Development and Disability Box 357920 Seattle, WA 98195-7920 (206) 543-9200 http://depts.washington.edu/chdd/ucedd/ucedd_infantmentalhealth.html	The Center on Infant Mental Health and Development is one of eight major programs of the University of Washington Center for Excellence in Developmental Disabilities. Its mission is to promote interdisciplinary research and training related to the social and emotional aspects of development for young children during their formative years.
American Orthopsychiatric Association Dept of Psychology, Box 871104 Arizona State University Tempe, AZ 85287-1104 (480) 727-7518 AmericanOrtho@asu.edu www.amerortho.org	The American Orthopsychiatric Association (“Ortho”) is an 80-year old membership association of mental health professionals concerned with clinical issues and issues of social justice. Ortho provides a common ground for collaborative study, research, and knowledge exchange among individuals from a variety of disciplines engaged in preventive, treatment, and advocacy approaches to mental health.

Organization and Contact Information	Description of Resources
California Childcare Health Program 1333 Broadway, Suite 1010 Oakland, CA 94612-1926 (510) 839-1195 phone (800) 333-3212 Healthline www.ucsfchildcarehealth.org	CCHP is a community-based program of the University of California, San Francisco (UCSF) School of Nursing, Department of Family Health Care Nursing. The multidisciplinary team staffs a toll-free Child Care Healthline, trains professionals on health and safety issues related to ECE programs, and conducts research. CCHP produces a wealth of materials on health and safety in ECE settings for professionals and families. Publications on Web site include: Health and Safety Notes, Facts to Families about behavioral health issues. Most educational items are available in English and Spanish.
Center on the Social and Emotional Foundations for Early Learning University of Illinois at Urbana-Champaign Children's Research Center; 51 Gerty Drive; Champaign, IL 61820 (877) 275-3227 phone (217) 244-7732 fax http://csefel.uiuc.edu	The Center on the Social and Emotional Foundations for Early Learning is a national center focused on strengthening the capacity of Child Care and Head Start to improve the social and emotional outcomes of young children. The center will develop and disseminate evidence-based, user-friendly information to help early educators meet the needs of the growing number of children with challenging behaviors and mental health needs in Child Care and Head Start programs.
Centers for Disease Control and Prevention (800) 311-3435 www.cdc.gov	The Centers for Disease Control and Prevention (CDC) is recognized as the lead federal agency for protecting the health and safety of people in the United States. National Center for Chronic Disease Prevention and Health Promotion; Mental Health Work Group. Mental health organizations listed by state. www.cdc.gov/mentalhealth/state_orgs.htm CDC seeks to give people accurate and timely information about public health and the Autism Spectrum Disorders. www.cdc.gov/ncbddd/autism
Children and Adults with Attention Deficit/Hyperactivity Disorder 8181 Professional Place, Suite 150, Landover, MD 20785 www.chadd.org	Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) is a national nonprofit organization providing education, advocacy and support for individuals with AD/HD. In addition to our informative Web site, CHADD also publishes a variety of printed materials to keep members and professionals current on research advances, medications and treatments affecting individuals with AD/HD.
Civitas 1327 W. Washington Boulevard Suite 3D Chicago, IL 60607 (312) 226-6700 phone (312) 226-6733 fax www.civitas.org	Using the latest research in early childhood development, Civitas produces and distributes practical, easy-to-use tools that assist adults in making the best possible decisions on behalf of children.

Organization and Contact Information	Description of Resources
Council for Exceptional Children Division of Early Childhood 1110 North Glebe Road, Suite 300, Arlington, VA 22201 (703) 620-3660 phone (866) 915-5000 TTY (703) 264-9494 fax service@cec.sped.org www.cec.sped.org	The Council for Exceptional Children (CEC) is the largest international professional organization dedicated to improving educational outcomes for individuals with exceptionalities, students with disabilities, and/or the gifted.
Department of Mental Health Health and Welfare Agency 1600 Ninth Street, Room 151 Sacramento, CA 95814 (916) 654-3565 phone (916) 654-3198 fax (800) 896-4042 toll-free (800) 896-2512 TDD dmh@dmhhq.state.ca.us www.dmh.cahwnet.gov	The California Department of Mental Health, entrusted with leadership of the California mental health system, ensures through partnerships the availability and accessibility of effective, efficient, culturally competent services. This is accomplished by advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services.
Early Childhood Research Institute CLAS University of Illinois at Urbana-Champaign 61 Children's Research Center 51 Gerty Drive Champaign, IL 61821 (217) 333-4123 phone (877) 275-3227 toll-free http://clas.uiuc.edu	The Early Childhood Research Institute on Culturally and Linguistically Appropriate Services (CLAS) identifies, evaluates, and promotes effective and appropriate early intervention practices and preschool practices that are sensitive and respectful to children and families from culturally and linguistically diverse backgrounds. The CLAS Web site presents a dynamic and evolving database of materials describing culturally and linguistically appropriate practices for early childhood/early intervention services. In this site, you will find descriptions of books, videotapes, articles, manuals, brochures and audiotapes. In addition, there are extensive web site links and information in a variety of languages. The CLAS Institute is funded by the Office of Special Education Programs of the U.S. Department of Education.
Federation of Families for Children's Mental Health 1101 King Street, Suite 420 Alexandria, Virginia 22314 (703) 684-7710 phone (703) 836-1040 fax www.ffcmh.org	The National family-run organization dedicated exclusively to helping children with mental health needs and their families achieve a better quality of life.
National Alliance for Autism Research National Office 99 Wall Street, Research Park Princeton, NJ 08540 (888) 777-NAAR phone (609) 430-9163 fax www.naar.org	The mission of the National Alliance for Autism Research is to fund, promote and accelerate biomedical research and science-based approaches that seek to determine the causes, prevention, effective treatments and, ultimately, a cure for autism spectrum disorders.

Organization and Contact Information	Description of Resources
National Alliance for the Mentally Ill Colonial Place Three 2107 Wilson Blvd., Suite 300 Arlington, VA 22201-3042 (703) 524-7600 phone (800) 950-NAMI (6264) Helpline (703) 524-9094 fax www.nami.org	NAMI is a nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses, such as schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, autism and pervasive developmental disorders, attention deficit/hyperactivity disorder, and other severe and persistent mental illnesses that affect the brain.
National Association for the Education of Young Children 1509 16th St. N.W. Washington DC 20036 (202) 232-8777 phone (800) 424-2460 toll-free www.naeyc.org	NAEYC Love and Learn, Positive Guidance for Young Children www.journal.naeyc.org/btj/200307/love-learn.asp NAEYC Brochures for Families www.naeyc.org/families/brochures.asp NAEYC Resources for Teachers, Strengthening Families Resource Guide www.naeyc.org/ece/supporting/resources.asp
National Clearinghouse on Family Support and Children's Mental Health Portland State University P.O. Box 751 Portland, OR 97207-0751 (800)628-1696 or (503)725-4040 www.rtc.pdx.edu	The Center is dedicated to promoting effective community-based, culturally competent, family-centered services for families and their children who are, or may be affected by mental, emotional or behavioral disorders.
National Institute of Mental Health (NIMH) Office of Communications 6001 Executive Boulevard, Room 8184, MSC 9663 Bethesda, MD 20892-9663 (866) 615-6464 nimhinfo@nih.gov www.nimh.nih.gov	NIMH is the lead Federal agency for research on mental and behavioral disorders. Their Web site describes many of the mental disorders affecting children and adolescents include the following: Attention Deficit Hyperactivity Disorder (ADHD, ADD) Autism Spectrum Disorders (Pervasive Developmental Disorders) Bipolar Disorder Borderline Personality Disorder Depression Eating Disorders Childhood-Onset Schizophrenia
National Mental Health Association 2001 N. Beauregard Street, 12th Floor Alexandria, VA 22311 (703) 684-7722 phone (703) 684-5968 fax www.nmha.org	The National Mental Health Association is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness.
Parents Helping Parents - San Francisco, Inc. 4752 Mission Street, Ste. 100 San Francisco, CA 94112 (415) 841-8820 phone (415) 841-8824 fax sfphp@earthlink.net www.sfphp.com	Parents Helping Parents - SF (PHP), is a nonprofit organization based in San Francisco, California formed by concerned parents working in cooperation with other nonprofit agencies and various federal, state and local agencies committed to alleviating some of the problems, hardships and concerns of families with children that have special needs.

Organization and Contact Information	Description of Resources
The Preventive Ounce www.preventiveoz.org	This interactive Web site lets you see more clearly your child's temperament, find parenting tactics that work for your child.
Program for Infant Toddler Caregivers 180 Harbor Drive, Suite 112 Sausalito, CA 94965-1410 (415) 289.2300 phone (415) 289.2301 fax www.pitc.org	The Program for Infant Toddler Caregivers seeks to ensure that America's infants get a safe, healthy, emotionally secure and intellectually rich start in life. Its three pronged mission is to 1) increase the availability and quality of child care for all children under age three; 2) disseminate information that increases the practice of responsive, respectful and relationship based infant toddler care; and 3) influence national, regional and local policies and practices so that the needs and interests of individual infants, toddlers, and their families are the foundation for all curriculum development and program activity.
U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration(SAMHSA) National Mental Health Information Center The Center for Mental Health Services. Child, Adolescent, and Family Branch P.O. Box 42557 Washington DC 20015 (800) 789-2647 (866) 889-2647 TDD (301) 984-8796 fax	Child, adolescent and family (2003). www.mentalhealth.org/cmhs/ChildrensCampaign. Leading the nation's mental health system into the 21st century (2002). www.mentalhealth.org/publications/allpubs/SMA02-3623/default.asp. www.mentalhealth.samhsa.gov/topics/explore/children Mental health facilities locator advanced search www.mentalhealth.org/databases/kensearch.asp State/territory resources www.mentalhealth.org/publications/Publications_browse.asp? ID=185&Topic=State%2FTerritory+Resources
ZERO TO THREE: National Center for Infants, Toddlers and Families 2000 M Street, NW, Suite 200 Washington, DC 20036 (202) 638-1144 www.zerotothree.org	ZERO TO THREE's mission is to promote the healthy development of our nation's infants and toddlers by supporting and strengthening families, communities, and those who work on their behalf. We are dedicated to advancing current knowledge; promoting beneficial policies and practices; communicating research and best practices to a wide variety of audiences; and providing training, technical assistance and leadership development.

Publications

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HANDOUTS FOR BEHAVIORAL HEALTH MODULE

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Health & Safety Notes
California Childcare Health Program

Understanding and Caring for the Child with ADHD

What is ADHD?

Attention-Deficit/Hyperactivity Disorder (ADHD) is a condition that causes a person to be overactive and impulsive and/or have difficulty paying attention. These behaviors often appear in early childhood before age 7 but may also be detected when the child is older.

Diagnosis

ADHD affects approximately 3 to 5 percent of all school-age children, possibly as many as 2 million children in the United States. ADHD is three times more common in boys than girls and tends to run in families. Many children continue to have behaviors of ADHD as adults. ADHD affects all socioeconomic, cultural and racial backgrounds. More than 20 percent of children with ADHD also have learning disabilities. However, having a diagnosis of either ADHD or learning disability is not related to intelligence.

Diagnosis of ADHD is made by a physician, psychiatrist, psychologist or licensed social worker, with close collaboration and input from the parents, teacher(s), and/or the child care provider(s). Children with ADHD demonstrate behaviors that generally fall into three different categories: inattention, hyperactivity and impulsivity.

Examples of inattention (trouble paying attention) would include a child who:

- Makes careless mistakes
- Has difficulty paying attention in tasks or play activities
- Does not seem to listen to what is being said
- Does not follow through or finish activities or tasks
- Has difficulty organizing tasks and activities
- Avoids or strongly dislikes routine tasks or activities
- Is easily distracted and forgetful

Examples of hyperactivity (being very active) would include a child who:

- Fidgets with hands and feet, or squirms in seat
- Has difficulty playing quietly
- Is "on the go" or acts as if "driven by a motor"
- Talks excessively
- Has difficulty waiting in line or for a turn

Examples of impulsivity (acting before thinking) would include a child who:

- Blurts out answers to questions before they have been completed
- Has difficulty waiting in lines or waiting his turn
- Interrupts or intrudes on others

All of these behaviors are common for children at different ages and stages of development. For example, many 2-year-olds are "on the go" and seem to have short attention spans. For a child to be diagnosed with ADHD, some of the behaviors listed above must have appeared before the child was 7 years of age, have lasted for at least six months, and should be happening frequently enough to cause concern both at home and at school or the child care setting.

Causes

Scientists have not been able to determine the exact cause of ADHD, though the research suggests that it may be caused by a chemical imbalance or a lack of certain chemicals in the brain which are responsible for attention and activity. There is also evidence that if one or both parents have ADHD, then their children are more likely to show symptoms as well. Exposure to toxins (including drugs and/or alcohol during pregnancy), brain injury and childhood illness may also contribute to the cause of ADHD. ADHD is not caused by too much television, poor parenting or poor schools.

Treatment

All interventions for children with ADHD should help to build the child's sense of self-esteem. A team approach using educational, psychological, behavioral and medical techniques is recommended and requires an effort by parents, teachers, child care and health care providers to find the right combination of responses.

Children with ADHD are typically "hands-on" learners and often will respond to:

- Stimulating or novel activities
- Lower adult-child ratios
- Predictable environments
- Individualized programming
- Structure, routine and consistency
- Motivating and interesting curricula
- Shorter activity periods
- Use of positive reinforcers
- Supplementing verbal instruction with visual aids.

Medication has been used successfully for children with ADHD as a *part* of the treatment plan—never alone. Stimulant medications have been found to improve symptoms such as attention span, impulse control and hyperactivity, with minimal side effects. Child care providers should work closely with families and health providers when a child is on medication and note any changes in behavior.

Counseling is also an important component of the treatment plan as it can help improve the child's self-esteem, impulse control, and compliance with taking medications, as well as help address some of the behavioral issues. It may also be helpful to have the family involved in the counseling or support groups, as ADHD affects the whole family, not just the diagnosed child.

Physical activities can help the child with ADHD to improve coordination and self-esteem as well as provide appropriate outlets for extra energy.

Some parents may use special diets to eliminate foods that cause problems. Though there is no scientific evidence of specific foods or allergies causing ADHD, many families believe that eliminating certain foods has improved the child's behavior.

Tips for Child Care Providers

- Learn what you can about ADHD.
- Ask the child's parents for suggestions and tips that they have found useful at home.
- Try to be consistent with the ways the child's parents guide and manage his or her behavior.
- Let the child take regular breaks and have access to a quiet place to regroup.
- Provide step-by-step instructions.
- Have clear rules and consistent schedules for the child.
- Don't forget to look for and praise good behavior.

Is ADHD covered under the IDEA or ADA?

Children diagnosed with ADHD may be eligible for special education and related services under the Individuals with Disabilities Education Act (IDEA). Children who do not qualify for special education services, but still need environmental or other modifications to the program and/or environment, may be eligible under Section 504 of the Rehabilitation Act of the Americans with Disabilities Act (ADA). For more information, children should be referred to their local school district to see if they qualify for services.

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Health & Safety Notes
California Childcare Health Program

Caring for the Spirited Child

Not all children are the same. Some are easygoing and others are more challenging because they are strong-willed, easily frustrated, very active, have very intense emotions, and/or have trouble with changes, transitions or situations that are new.

Learning about *temperament* can help you understand and work more effectively with children. Temperament is each person's natural inborn style of interaction that we use to influence and respond to the world around us.

Who is a spirited child?

All toddlers are busy, but the spirited child is much busier. If you care for a spirited child you will have more on your hands. While a high-energy child is typical, some are more intense, persistent and empathetic than other children.

How to identify a spirited child?

Likes to perform. She may be charming, and among her peers she may be recognized as a charismatic leader. She may seem always hungry for attention and loves being the center of attention. She may feed on external stimulation including needing feedback from others.

Insatiable. He often demands immediate responses from you, and sometimes whatever you do, it does not seem to satisfy him.

High energy level. She may be physically active, always exploring, and unable to slow herself down without help. She may be restless, fidgety, constantly on the move. She may have no sense of what is appropriate behavior and may not follow rules.

Has a hard time adapting. Fearful of new situations, he may cling to you. He may need extra time to make transitions to new routines or activities. He may be shy and reserved when meeting new people. He may "lock in" to important ideas, and may love to debate.

Intelligent. She is often bright, even gifted. She is creative and frequently a keen observer.

Needs less sleep. He may wake up often at night and may not take a nap during the daytime. He may not keep to a regular schedule for sleeping.

Extra sensitive. If usually sensitive to sights, sounds, smells, tastes and skin sensations, she may be quickly and easily over-stimulated by what is going on around her. She may hate to be confined physically.

Demanding. He often needs your attention constantly. He usually has very strong preferences in most matters.

Emotionally intense. Everything is black or white, happy or sad—there is no middle ground in her choices, opinions or life in general. As an infant, she cried more than others. She is usually loud and forceful whether miserable, happy or angry.

Working with the spirited child

Provide quality time. Though the child may be gaining some independence, it is best to maintain a day-to-day special time with just him. Find a favorite song or book that both of you enjoy together daily. This establishes a trust that you will always be there, focusing on the development of a meaningful adult-child relationship.

Keep her informed. When you explain to a child what she should expect, it defuses anxiety about what is coming. For example, offer advanced notice when an activity is about to end. "When we finish reading this book, we're going to wash our hands and get ready for lunch." Prepare and support the child for major and minor changes in the daily routine. Allow

a little extra time for this child to move from one activity to another.

Be consistent. High-spirited children need rules and limits. Express expectations simply and directly. And once you set the rules, stick to them by creating a predictable plan for activities, mealtimes, naptimes, etc. and adhere to it as much as possible.

Anticipate. If a high-spirited child acts up in certain places or situations, make other arrangements or adjustments. Acknowledge his reality and show you understand by validating his feelings, which helps to protect his sense of autonomy. "I know it's hard for you to be in crowded, noisy places. I know that it can be overwhelming." Offer physical comfort when he is distressed. Try giving him a big hug or massaging his back.

Offer praise. Positive reinforcement offers encouragement and raises a child's self-esteem. When she sits through and finishes her lunch without getting distracted, let her know that you are pleased with her progress. Be specific. Instead of saying "good girl," share with her exactly what you are delighted about, such as "I like the way you were able to eat your lunch with your friends today."

Let him help. When a child wants to start doing things for himself, let him. It may take a few extra minutes or become messy, but it will probably prevent tantrums and power struggles, and it will promote self-mastery. For example, let him put on his own shoes, or set the table for dinner.

Avoid labels. Be careful how you describe a child. Labels have a tendency to stick and affect a child's self-esteem. Focus on the child's positive attributes, her strengths and competencies, rather than her difficulties and weaknesses. Instead of saying, "Jaime is so stubborn and bad," try "Jaime knows what she likes and is energetic." *Respect* her pace and style.

Do not punish him for who he is. He is not *overreacting*...he just needs help to express his strong feelings in a more appropriate manner. Proactively teach and model acceptable expressions of anger, sadness, fear and frustration.

All behavior has meaning. Specific behaviors may mean different things to different people, but they mean something. We must appreciate that a child's behavior and style are a combination of many things: age, personality, temperament, cultural roots, family traditions and expectations, experience, etc. And we may not always get it right, but it is important to understand *your* perception of the child's behavior and temperament. It is *not* about changing the child; rather you must seek ways to accommodate in order to meet the child's individual needs.

Temperament describes how a child reacts, not why she reacts in a particular way. Remembering that temperamental styles are part of the child's nature helps us to better understand the child's experience. And that in turn helps us to respond constructively to the child's strengths and needs.

Additional Resources

Spirited Kids Family Resource Center at *www.network54.com/Realm/Spirited_Kids.*

The Preventive Ounce at *www.preventiveoz.org.*

Civitas at www.civitas.org.

Raising Your Spirited Child: A Guide for Parents Whose Child Is More Intense, Sensitive, Perceptive, Persistent, and Energetic. Kurcinka, M.S. (1991). New York, NY: HarperCollins.

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Health & Safety Notes
California Childcare Health Program

Biting in the Child Care Setting

Biting causes more upset feelings than any other behavior in child care programs. Because it seems so primitive, we tend to react differently to biting than we do to hitting, grabbing or other aggressive acts. Because it is upsetting and potentially dangerous, it is important for caregivers and parents to address this behavior when it occurs. Though it is normal for infants and toddlers to mouth people and toys, and for many two-year-olds to try biting, most do not continue after the age of three.

Why do children bite and what can we do?

Children bite for many different reasons, and careful observation will guide your appropriate and effective intervention. Taking the time to understand why a particular child bites is invaluable in changing the behavior while maintaining a positive caregiving relationship.

Watch to see when and where biting happens, who is involved, what the child experiences, and what happens before and after.

Ask yourself why the child bites others. Is there a pattern to the situations, places, times or other children when biting occurs? What individual or temperamental needs might influence the child's behavior? Have there been changes in the child's health, family or home situation which might affect his/her behavior?

Adapt your environment, schedule or guidance methods to teach gentle and positive ways to handle the child's feelings and needs.

When a child bites another child

Intervene immediately between the child who bit and the bitten child. Stay calm; don't overreact, yell or give a lengthy explanation.

Talk briefly to the child who bit. Use your tone of voice and facial expression to show that biting is not acceptable. Look into the child's eyes and speak calmly but firmly. Say, "I do not like it when you bite people." For a child with more limited language, just say "No biting people." You can point out how the biter's behavior affected the other child. "You hurt him and he's crying."

Help the child who was bitten. Comfort the child and apply first aid. If the skin is broken, wash the wound with warm water and soap. Apply an ice pack or cool cloth to help prevent swelling. Tell the parents what happened, and recommend that they have the child seen by a physician if the skin is broken or there are any signs of infection (redness or swelling). Encourage the child who was bitten to tell the biter "You hurt me."

Encourage the child who bit to help the other child by getting the ice pack, etc.

Observe universal precautions if there is bleeding.

Alert the staff to the incident.

Notify the parents of all children who were involved. Let them know what happened but do not name or label the child who bit. Reassure them by telling how you handled the incident, and involve the parents in planning how to prevent and handle future biting.

When biting continues after several weeks

Plan a more concentrated program of intervention.

Meet with the parents of the child who is biting to discuss possible reasons and plan together to change the biting behavior.

Assign a special person to stay with the child to carry out the plan determined by the parents and staff with the aim of teaching and giving positive attention for acceptable social behavior.

When the child bites, use the techniques listed above and remove the child from the area where the biting took place. Tell the child he or she cannot play in the area where the biting took place for a while. (This is redirection, not a "time-out.")

If the child continues biting or does not seem to care about the consequences, seek professional help and/or explore the possibility that the child needs an environment with fewer children and more one-on-one adult attention.

Older preschoolers who continue to bite should be referred for more assessment and help.

What can programs do to handle biting?

Develop a policy for guidance and discipline which includes biting. Clearly state how you will handle biting occurrences for both the child who was bitten and the child who bites.

Communicate your policy with parents and staff before biting occurs. Reassure parents that this behavior is not uncommon and that you plan to work with the child in developing positive social skills.

Prevent biting by being alert to potential problem situations.

- Evaluate your program for stressors such as changes in providers or children, crowded play areas or insufficient materials which make children wait for turns, schedules requiring children to make many transitions, tired children at the end of the day.
- When a child is starting in your program, ask the parents whether biting or other aggressive behavior has been an issue and how it has been handled in the past.
- Be alert for children who are likely to bite based on past history.
- Remember that biting tends to be more common during the late summer and early fall months (perhaps due to lighter clothing or changes in the grouping of children).

Reinforce desired behavior. Notice and acknowledge when you like what the child is doing. Provide positive guidance for showing empathy or social behavior, such as patting a crying child, offering to take turns with a toy or hugging gently.

Help the child make connections with others. Encourage special relationships with caregivers, talk about how others feel, express empathy for the feelings of other children.

Do not label, humiliate or isolate a child who bites another child.

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Children Who Bite, by Donna Witmer, Scholastic Pre-K Today, March 1998.

When Children Bite. National Network for Child Care. Christine Todd. www.nncc.org/Guidance/dc16_children.bite.html.

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by Cheryl Oku, Infant-Toddler Specialist (rev. 06/04)

When a child	You can
Experiments by biting	• Immediately say "no" in a firm voice. • Give him a variety of toys and materials to touch, smell and taste and encourage sensory-motor exploration.
Has teething discomfort	• Provide cold teething toys or chewy foods.
Is becoming independent	• Provide opportunities to make age-appropriate choices and have some control (the pretzel or the cracker, the yellow or the blue ball). • Notice and give positive attention as new self-help skills and independence develop.
Is using muscles in new ways	• Provide a variety of play materials (hard/soft, rough/smooth, heavy/light). Plan for plenty of active play both indoors and outdoors.
Is learning to play with other children	• Try to guide behavior if it seems rough. (Take the child's hand and say, "Touch Jorge gently. He likes that.") • Prevent conflicts by offering more than one of any especially attractive toy and creating open play space. • Reinforce pro-social behavior (like taking turns with toys or patting a crying child).
Is frustrated in expressing his/her needs and wants	• "Read" the child and say what he is trying to communicate. ("You feel mad when Ari takes your truck." "You want me to pay attention to you.")
Is threatened by new or changing situations such as a mother returning to work, a new baby, or parents separating	• Provide some special nurturing and be as warm and reassuring as possible, adding some stability and continuity to the child's life. • Help the child talk about feelings even when he or she says thing like "I hate my new baby."

California Childcare Health Program • 1333 Broadway, Suite 1010 • Oakland, CA 94612-1926
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Health & Safety Notes
California Childcare Health Program

Temperament and Regularity

It can certainly be difficult to manage children with widely different temperaments. *Regularity* is one of the traits which define temperament. Children who are *regular* and predictable in their daily routines like to eat, sleep and have bowel movements (BMs) at about the same time almost every day. If children are extremely regular, then you can practically set your watch by when they do things every day.

If a child is *irregular,* then it is hard to predict when he or she will want to eat, nap or have a BM. The child's biological schedule may be different every day. Maintaining a consistent routine between child care and home (even on the weekends) may help this child to regulate, but do not expect that the child will be as predictable as the more regular child.

Working with a particular child's temperament

Regular and irregular temperaments each bring their own challenges, especially if an irregular child is matched with a child care provider or parent who is regular, or vice versa. It can be frustrating for a regular child care provider or parent to try and predict the needs of an irregular child around such routines as mealtime, naps and elimination.

It's easy to plan outings, snack times and diapering needs for regular children because their habits are predictable. However, very regular children can be dramatically thrown off their schedules for a short period of time by changes such as daylight savings time. They may feel a little disoriented, almost as if they have jet lag.

While irregular children are more difficult to predict, they are also less likely to be upset by changes in routine. Irregular children are more likely to adapt to variable routines without much of a problem. However, if a child is consistently refusing to eat at lunchtime, sleeps without a pattern of consistency, and has three BMs today and none tomorrow, this child may have a *very irregular* temperament. Ask the parent about the child's routines at home and if there are ways that consistency can be promoted in the child care setting. Parents may not be aware that their child's body can't be as routine-oriented as the other children, or even their own siblings, and they may see the irregularity of the child's response as deliberate or manipulative.

Working with parents

You may hear from parents whose children respond regularly at child care due to the consistency of the child care environment, but are irregular at home. This is a great opportunity to share your knowledge of temperament with them so that you can work together to meet this child's needs. Be sensitive when sharing information with parents who are frustrated by their child's irregularity, as it may seem to reflect on their parenting abilities.

by Susan Jensen, RN, MSN, PNP (rev. 03/03)

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The Program for infant toddler caregivers

Goals for
THE EMOTIONALLY HEALTHY CHILD AT AGE THREE OR FOUR

1. Has warm, _____ , intimate relationships with other children and adults

2. Shows _____ self-esteem: feels good about what she or he does

3. Uses good control of impulses and _____: handles assertiveness, curiosity, and angry protest in ways that are in accord with:
   a. society's _____
   b. norms for _____ group
   c. the _____ the child finds herself or himself in, such as preschool, church, playground

4. Separates _____ from reality and adjusts to the demands of reality

5. Exhibits a _____ imagination:
   a. Incorporates and _____ feelings
   b. Uses _____ to express needs, feelings, and ideas

6. Shows _____ and _____ for others; deals with _____ and the limitations of life

7. Concentrates, _____, and plans as a basis for learning in educational settings.

A VISION FOR SOCIAL AND EMOTIONAL DEVELOPMENT

1. **The Self:** The caregiver provides physical and emotional security for each child and helps each child to know, accept, and take pride in herself or himself and to develop a sense of independence.

2. **Social Skills:** The caregiver helps each child feel accepted in the group, assists children in learning to communicate and get along with others, and encourages feelings of empathy and mutual respect among children and adults.

3. **Guidance:** The caregiver provides a supportive environment in which children can begin to learn and practice appropriate and acceptable behaviors as individuals and as a group.

The Program for infant toddler caregivers

ANSWER KEY

THE EMOTIONALLY HEALTHY CHILD AT AGE THREE OR FOUR

1. Has warm, trusting, intimate relationships with other children and adults

2. Shows positive self-esteem: feels good about what she or he does.

3. Uses good control of impulses and behavior: handles assertiveness, curiosity, and angry protest in ways that are in accord with:
   a. society's goals (expectations)
   b. norms for peer group
   c. the settings the child finds herself or himself in, such as preschool, church, playground

4. Separates make-believe (fantasy) from reality and adjusts to the demands of reality.

5. Exhibits a rich imagination:
    a. Incorporates and labels feelings
    b. Uses words to express needs, feelings, and ideas

6. Shows empathy and compassion for others; deals with loss and the limitations of life.

7. Concentrates, focuses, and plans as a basis for learning in educational settings

A TEMPERAMENT TREASURE HUNT

Instructions: Walk around the room and talk to one person at a time. See if you can find someone who fits each of the following descriptions. Each name can only be used once. Good luck!

Can you find some one who:

- Their foot is always wiggling. _____
- Never asks a stranger for directions. _____
- Goes to bed at the same time every night. _____
- Can sit and read for hours at one time. _____
- Takes her shoes off whenever she can. _____
- Gets frustrated really easily. _____
- Doesn't enjoy meeting new people at a party. _____
- Can't stand tight or clingy clothes. _____
- Can always find a problem with a situation. _____
- Enjoys plenty of alone time. _____
- Prefers to watch awhile before joining an activity. _____
- Loves a difficult and complex puzzle. _____
- Goes to bed at a different time every night. _____
- Is on the go all day long. _____
- Is constantly starting something new. _____
- Is always in a good mood. _____
- Loves hot weather. _____

Developed by Alice Nakahata for The Program for Infant/Toddler Caregivers (PITC). Modified by Mardi Lucich, MA 2/03 for the California Childcare Health Program (CCHP) www.ucsfchildcarehealth.org

TEMPERAMENT ASSESSMENT SCALE FOR CHILDREN

By answering the following questions for each child, you can increase your understanding of the temperament of the children you serve. Plot your responses on the accompanying graph using different colors for each child in your care.

Activity Level

How much does the child wiggle and move around when being read to, sitting at a table, or playing alone?

1 2 3 4 5

High Activity Low Activity

Biological Rhythms/Rhythmicity

Is the child regular about eating times, sleeping times, amount of sleep needed and bowel movements?

1 2 3 4 5

Regular Irregular

Adaptability

How quickly does the child adapt to changes in her or his schedule or routine? How quickly does the child adapt to new foods or places?

1 2 3 4 5

Adapts Quickly Slow to Adapt

Approach/Withdrawal

How does the child usually react the first time to new people, new foods, new toys and new activities?

1 2 3 4 5

Approaches Withdraws

Sensitivity/Sensory Threshold

How aware is the child of slight noises, slight differences in temperature, differences in taste and differences in clothing?

1 2 3 4 5

Low Sensitivity High Sensitivity

Intensity of Reaction

How strong or violent are the child's reactions? Does the child laugh and cry energetically, or does she or he just smile and fuss mildly?

1	2	3	4	5
High Intensity				Mild Reaction

Distractability

Is the child easily distracted, or does she or he ignore distractions? Will the child continue to work or play when other noises or children are present?

1	2	3	4	5
High Distractibility				Low Distractibility

Quality of Mood

How much of the time does the child show pleasant, joyful behavior compared with crying and fussing behavior?

1	2	3	4	5
Positive Mood				Negative Mood

Persistence

How long does the child continue with one activity? Does the child usually continue if it is difficult?

1	2	3	4	5
High Persistence				Low Persistence

Adapted from The Program for Infant/Toddler Caregivers (PITC) www.pitc.org Trainers Manual, Module I: Social-Emotional Growth & Socialization

TEMPERAMENT ASSESSMENT SCALE FOR CAREGIVERS

By answering the following questions for yourself, you can increase your understanding of your own temperament. Plot your responses on the accompanying graph.

Activity Level

How much do you wiggle and move around when reading, sitting at a table, watching television, etc?

1	2	3	4	5
High Activity				Low Activity

Biological Rhythms/Rhythmicity

Are you regular about eating times, sleeping times, amount of sleep needed and bowel movements?

1	2	3	4	5
Regular				Irregular

Adaptability

How quickly do you adapt to changes in your schedule or routine? How quickly do you adapt to new foods or places?

1	2	3	4	5
Adapt Quickly				Slow to Adapt

Approach/Withdrawal

How do you usually react the first time to new people, new foods and new activities?

1	2	3	4	5
Approaches				Withdraws

Sensitivity/Sensory Threshold

How aware are you of slight noises, slight differences in temperature, differences in taste and differences in clothing?

1	2	3	4	5
Low Sensitivity				High Sensitivity

Intensity of Reaction

How strong or violent are your reactions? Do you laugh and cry energetically, or do you just smile and fret mildly?

1	2	3	4	5
High Intensity				Mild Reaction

Distractability

Are you easily distracted, or do you ignore distractions? Will you continue to work or stay engaged when other noises or people are present?

1	2	3	4	5
High Distractibility				Low Distractibility

Quality of Mood

How much of the time do you show pleasant, joyful behavior compared with upset and agitated behavior?

1	2	3	4	5
Positive Mood				Negative Mood

Persistence

How long do you continue with one activity? Do you usually continue if it is difficult?

1	2	3	4	5
High Persistence				Low Persistence

Adapted from The Program for Infant/Toddler Caregivers (PITC) www.pitc.org Trainers Manual, Module I: Social-Emotional Growth & Socialization

UNDERSTANDING A CHILD'S BEHAVIOR

Child _____/**Age**____ **Date** _____

Behavior:

Cause (Describe indicators)	**Strategies Tried**	**Additional ideas/strategies to teach/guide appropriate behavior**
Developmental Stage		
Individual Differences		
The Environment		
Doesn't know-Ready to learn		
Unmet Need		

From PITC handout, *Toward a Better Understanding of Children's Behavior*
Adapted by K. Johnston and L. Thompson from Janes Hymes' Understanding Your Child

THINGS TO CONSIDER

WHAT IS YOUR IDEAL CHILD?

active	approaching	cautious	cooperative	dependable
honest	independent	industrious	loyal	obedient
persistent	quiet	predictable	playful	assertive
confident	curious	sensitive	sense of humor	spirited
		takes risks		

Janet Poole, Program for Infant/Toddler Caregivers, WestEd

What to Expect . . .*

Much of the behavior of young children that is annoying to adults is normal and is part of the child's learning process and growth. Adults can save themselves much worry and trouble if they know what to expect from children at different stages of development.

Of course, none of the 555 children in the study did any of these things all of the time. But all of the children did some of these things some of the time. Large percentages did some of them almost daily.

Most 2, 3 and 4 year olds:

- *Pay no attention to what they are asked to do*
- *Say "no;" refuse to do what is expected or asked*
- *Are poky, waste time eating, dressing, etc.*
- *Leave tasks undone, start but don't finish*
- *Wriggle; don't sit still*
- *Laugh, squeal, jump around*
- *Grab toys, shove, hit, attack others*
- *Refuse to share things with other children*
- *Ask" unnecessary" questions*
- *Cry, sulk easily*
- *Pick nose, play with fingers*
- *Stay close to adults*
- *Seek attention by showing off, look for praise*
- *Go to adults with criticism of others*
- *Boss others*
- *Stay awake at nap time; don't want to rest*
- *Refuse food*
- *Speak indistinctly*
- *Are hard to reason with*

Of course, none of the 555 children in the study did any of these things all of the time. But all of the children did some of these things some of the time. Large percentages did some of them almost daily.

*From *"Including All of Us" Caring for Children with Special Needs in Early Childhood Settings: Module III Handout*

TEMPERAMENT AND BEHAVIOR

Temperament is the **how** of behavior or behavioral style.

Ability is the **what** of behavior or content

Motivation is the **why** or reason behind the behavior.

from The Emotional Life of the Toddler, Alicia Lieberman

Temperament is thought to be a set of relatively stable tendencies to react in certain ways.

These tendencies can be **magnified,** downplayed, or ***changed in quality*** depending on the nature of one's encounters in the environment.

Supporting the Three Types of Temperaments

Temperament Type	Helpful Techniques	Things to Remember
Flexible: - Regular rhythms - Positive mood - Adaptability - Low intensity - Low sensitivity	+Check in regularly +Set aside special time	>Can be "invisible" >Can be taken advantage of
Fearful - Adapts slowly - Withdraws - Not highly active - Express emotions mildly	+Allow to observe from sidelines +Draw child in slowly +Allow independence to unfold.	Frequently: >Labeled insecure >Ridiculed for natural tendencies >Parents may feel social pressure
Feisty - Active/Tends to approach - Intense reactions - Distractible - Sensitive - Irregular rhythms - Moody - Often field independent	+Use redirection +Be flexible +Prepare the child for change +Make the most of quiet moments +Provide for vigorous play	>Problems eating, sleeping, etc. >Need secure base even more >Don't take behavior personally >Use sense of humor >Be available >Clear guidelines >Use support with, and time out from, child >Parents may feel criticized

From PITC Trainer's Manual Module I, *Resource Materials for Module I* (Temperaments Powerpoint handouts developed by Janet Poole), and *Fearful, Flexible, or Feisty* Video Magazine

REFRAMING SOME COMMON ATTITUDES ABOUT DISCIPLINE		
Get rid of conflict	⇒	Conflict is inevitable. Use it to teach.
Same problems over & over	⇒	What skills are missing?
Discipline interrupts teaching	⇒	Discipline/guidance is a key part of curriculum

Adapted from: Reframing Discipline Unit 1, Educational Productions, 1-800-950-4949

TECHNIQUES OF DIRECT GUIDANCE*

PHYSICAL

1. Give help based on the individual child's need.
2. Demonstrate or model the desired behavior or skill.
3. Lead the child by the hand to give direction, reassurance, or assistance.
4. Restrain the child where necessary to protect him or others.
5. Remove the child from the scene to help him relax and regain composure.
6. Use no punishment that is meant to hurt or humiliate the child.
7. Get down to eye level and use meaningful gestures.
8. Use your body language to help the child feel good about himself and comfortable in school.
9. Use gentle touch (slight pressure) to help children refocus.

VERBAL

1. Speak to the child eyeball to eyeball.
2. Use short sentences.
3. Use positive directions, telling the child what to do instead of what not to do.
4. Place the action part of your direction at the beginning of you r statement.
5. Give no more than two directions at a time, preferably only one.
6. Give the child directions when it is the time and place you want the behavior to occur.
7. Give only directions the child really needs.
8. Make it clear whether the child has a choice or not.
9. Give logical and accurate reasons for requests.
10. Keep competition to a minimum by motivating the child through helping him set new personal goals for achievement.
11. Praise the child for jobs well done.

AFFECTIVE

1. Give positive feedback for occasions other than when the child follows directions.
2. Give attention before the child demands it.
3. Reflect the feeling the child is expressing and give it a label.
4. Get to know the child better if you find yourself feeling negatively toward him.

*From "Including All of Us" Caring for Children with Special Needs in Early Childhood Settings: Module III Handout

BEHAVIORAL DATA COLLECTION SHEET

This sheet is intended to be used by caregivers to document a child's behavior that is of concern to them. The behavior may warrant evaluation by a health care provider, discussion with parents, and/or consultation with other professionals.

Child's name: _____ Date: _____

1. Describe behavior observed: (See below for some descriptions.)

   _____

2. Behavior noted from: _____ to _____
   (time) *(time)*

3. During that time, how often did the child engage in the behavior? (e.g. once, 2-5 times, 6-10 times, 11-25 times, >25 times, >100 times) _____

4. What activity(ies) was the child involved in when the behavior occurred? (e.g. was the child involved in a task? Was the child alone? Had the child been denied access to a special toy, food, or activity?) _____

5. Where did the behavior occur? _____

6. Who was around the child when the behavior began? List staff, children, parents, others.

   _____

7. Did the behavior seem to occur for no reason? Did it seem affected by changes in the environment?

   _____

8. Did the child sustain any self-injury? Describe. _____

9. Did the child cause property damage or injury to others? Describe. _____

   _____

10. How did caregiver respond to the child's behavior? If others were involved, how did they respond?

    _____

11. What did the child do after caregiver's response? _____

12. Have parents reported any unusual situation or experience the child had since attending child care?

Child Care Facility Name: _____

Name of Caregiver (completing this form): _____

Behaviors can include:

- *repetitive, self-stimulating acts*
- *self-injurious behavior (SIB) such as head banging, self-biting, eye-poking, pica (eating non-food items), pulling out own hair*
- *aggression / injury to others*
- *disruption such as throwing things, banging on walls, stripping*
- *agitation such as screaming, pacing, hyperventilating*
- *refusing to eat / speak; acting detached / withdrawn*
- *others*

Check a child's developmental stage before labeling a behavior a problem. For example, it is not unusual for a 12 month old to eat non-food items, nor is it unusual for an 18 month old to throw things. Also, note how regularly the child exhibits the behavior. An isolated behavior is usually not a problem.

S. Bradley, JD, RN,C - PA Chapter American Academy of Pediatrics
reviewed by J. Hampel, PhD and R. Zager, MD

TEMPERAMENT AND GOODNESS OF FIT

Easy or flexible children are generally calm, happy, regular in sleeping and eating habits, adaptable, and not easily upset. Because of their easy style, caregivers need to set aside special times to talk about the child's frustrations and hurts because he or she won't demand or ask for it. This intentional communication will be necessary to strengthen your relationship and find out what the child is thinking and feeling.

Slow to warm up or cautious children are relatively inactive and fussy, tend to withdraw or to react negatively to new situations, but their reactions gradually become more positive with continuous exposure. Sticking to a routine and your word, along with allowing ample time to establish relationships in new situations, are necessary to allow independence to unfold.

Difficult, active, or feisty children are often fussy, irregular in feeding and sleeping habits, fearful of new people and situations, easily upset by noise and commotion, high strung, and intense in their reactions. Providing areas for vigorous play to work off stored up energy and frustrations with some freedom of choice allow these children to be successful. Preparing these children for activity changes and using redirection will help these children transition (move or change) from one place to another.

Here are principles to keep in mind as you strive try to achieve "goodness of fit":

- **Be aware of the child's temperament and respect his/her uniqueness without comparing him/her to others or trying to change the child's basic temperament.** Encourage him/her to accomplish tasks at his own pace. Praising him/her for his/her ideas and achievements, however small, will enhance self-image and make him/her feel capable of being independent.
- **Be aware of your own temperament & your own needs, including the ways in which your role as a caregiver is colored by your relationship with your own parents/caregivers.** And adjust your natural responses when they clash with a child's responses.
- **Communicate.** Take time to explain your decisions and motives. And listen to the child's points of view. Encourage teamwork on generating solutions to problems.
- **Make your expectations clear by setting limits to help the child develop self-control.** Respect opinions but remain firm on important limits and decisions.
- **Be a good role model because children learn by imitation and identification as well as discussion.** Children take their cues from the adults around them.

To be more inclusive of a wider range of temperaments and differences in cultural values…some questions for reflection:

1. What traits are highly valued by families in your program?
2. Is there a "fit" between those values and individual children?
3. Is there a "fit" between those values and that of the program and staff?

SPECIAL CARE PLAN FOR A CHILD WITH BEHAVIOR PROBLEMS

This sheet is intended to be used by health care providers and other professionals to formulate a plan of care for children with severe behavior problems that parents and child care providers can agree upon and follow consistently.

Part A: To be completed by parent/custodian

Child's name: _____ Date of birth: _____

Parent name(s):_____ _____

Parent emergency numbers: _____ _____

Child care facility/school name: _____ Phone: _____

Health care provider's name: _____ Phone: _____

Other specialist's name/title: _____ Phone: _____

Part B: To be completed by health care provider, pediatric psychiatrist, child psychologist, or other specialist

1. Identify/describe behavior problem: _____
2. Possible causes/purposes for this type of behavior: (circle all that apply)

medical condition _____ *(specify)*

attention-getting mechanism

gain access to restricted items/activities

escape performance of task

psychiatric disorder _____

tension release

developmental disorder

neurochemical imbalance

frustration

poor self-regulation skills

other:

_____ *(specify)*

3. Accommodations needed by this child: _____

_____

4. List any precipitating factors known to trigger behavior: _____

_____

5. How should caregiver react when behavior begins? (circle all that apply)

ignore behavior

avoid eye contact/conversation

request desired behavior

use helmet*

physical guidance (including hand-over-hand)

model behavior

use diversion/distraction

use substitution

use pillow or other device to block self-injurious behavior (SIB)*

other: _____

_____

*directions for use described by health professional in Part D.

6. List any special equipment this child needs: _____

_____

7. List any medications this child receives:

Name of medication: _____	Name of medication:_____
Dose: _____	Dose: _____
When to use: _____	When to use: _____
Side effects:_____	Side effects:_____
_____	_____
Special instructions:_____	Special instructions:_____
_____	_____

8. Training staff need to care for this child: _____

_____

9. List any other instructions for caregivers: _____

_____

Part C: Signatures

Date to review/update this plan: _____

Health care provider's signature: _____ Date: _____

Other specialist's signature: _____ Date: _____

Parent signature(s): _____ Date: _____

_____ Date: _____

Child care/school director: _____ Date: _____

Primary caregiver signature: _____ Date: _____

Part D: To be completed by health care provider, pediatric psychiatrist, child psychologist, or other specialist

Directions for use of helmet, pillow, or other behavior protocol: _____

_____

_____

_____

_____

_____

_____

_____

S. Bradley, JD, RN,C - PA Chapter American Academy of Pediatrics
reviewed by J. Hampel, PhD and R. Zager, MD