Essential Elements of Providing Effective Infant and Early Childhood Mental Health Consultation

Nydia Ntouda: Our presenter today is Kadija Johnston, and she will formally introduce herself. Kadija

Kadija Johnston: Thank you. Thank you, Nydia. And welcome everyone. I'm coming to you from the Bay Area in California, so I will say good morning from my end and good afternoon or good evening. It's wonderful to see the geographic and rural range that is showing up in the chat. I'm Kadija Johnston, as Nydia said, and I am faculty at Georgetown University's Center for Child and Human Development where I have the privilege of being part of the National Center for Health, Behavioral Health, and Safety.

Today I'm going to speak with you about early childhood mental health consultation. What I bring to that topic is about 40 years of experience practicing, honing my practice, developing an approach to mental health consultation and how it can be effectively implemented in our instance in Head Start settings. This session is really aimed at, directed toward those of you providing the service.

My aim is to introduce, if you are newer, or remind you and confirm, for those of you who've been at this practice for a while, some of the essential perspectives and practices that really empirical evidence as well as our anecdotal experience are proving effective. Let me tell you the trajectory of our hour together. For most of our time, I will present proof and provide information on effective approaches to early childhood mental health consultation. I will leave what I hope will be ample time for reflection, comments, and questions at the end.

I recognize your thoughts don't wait till the end so, as Nydia just said, please throughout pose your questions in the question and answer section, and we'll get to those at the close of today's hour session. Amy Hunter, who I will address again and introduce when she comes on at the end, she is the co-lead for the behavioral health portion of this National Center on Health, Behavioral Health, and Safety, will be culling those questions and posing them to me when we get to them.

I want to begin, even for those of us who are very seasoned in the practice, with a definition, describing a definition of early childhood mental health consultation. I think a shared understanding of the practice is an important way to start no matter where in the terrain we enter from. So what is it? Infant and early childhood mental health consultation is a multi-level mental health strategy.

By multi-level, it means we address all levels of a Head Start system, from work directly with the front-line staff providers to being engaged with administrators, thinking about classroom level, systems level issues that impact everyone, as well as thinking about child-specific consultation.

It is not only multi-level but it also spans the care continuum from promotion to prevention to intervention. It's really that intersection of what I think of as depth and breadth that makes the service not only efficient and effective, but I would add quite elegant.

It is an indirect service, meaning what? That the intervention is aimed at the children and families, but it's enacted with the adults, with the providers. It pairs a mental health professional with other providers who care for, offer services to infants, toddlers, and young children and their families.

The purpose of the practice is to build capacities. What capacities do mental health consultants direct their interventions toward? I think increasing social and emotional awareness and knowledge and enhancing reflective competence and competence in the adults that surround young children. It's by collaborating with the primary people in children's lives that early childhood mental health consultation supports, or when needed, strengthens caregiving practices, and thereby promotes optimal development for all the children in a setting or service system.

While it is an effort that's directed at preserving and promoting the social and emotional well-being and relational health of all children and adults in a caregiving setting, mental health consultation simultaneously serves the intervention function for those children who are at risk for exhibiting or are already exhibiting mental health difficulties, but, again, through an indirect means, meaning working with the adults and the relationships they have directly with those children.

Sometimes it's also a way of understanding a service by talking about what it is not. To further flesh out the definition of early childhood mental health consultation, I want to say a little bit about what it isn't because there still exist misperceptions about the practice. What it is not, it is centered on not only a strength-based approach but also a relationship-focused approach, which means that it doesn't see a child as having a deficit or a disorder as residing inside the child. Rather, difficulties and even disturbance for a particular child is viewed as arising from relational experiences, from maybe relational disruptions or trauma.

Conversely, mental health consultation views relationships, those between the child and the teacher or child and the parent, as the place where healing happens. Our focus as mental health consultants is not to amend a deficient child but to surround the child with supportive relationships in a way that supports their development. We focus them on relational strength and establishing relational help.

As an indirect intervention, early childhood mental health consultation is not therapy for a child or sometimes providers also have needs for mental health services. Those needs are very valid, whether in an adult or a little one. Often, mental health consultation can serve a triage function, can help providers and children and families, one, destigmatize mental health services by having an experience with a mental health professional that doesn't immediately label or diagnose but rather gives a provider, a child, or a family an experience of mental health services that promotes the possibility that when direct mental health services are needed, it's more likely that a family will not only think about but secure those services with the help of Head Start staff and the mental health consultant.

Also, a common misperception is that observation – yes, one of the primary activities, which we'll turn to in a minute, of mental health consultation – is the primary activity. While important, observation is only one tool that allows us to understand a child who is struggling or

a center that isn't functioning, a program that isn't functioning as well as they would like, or a provider whose well-being is interfering with her wish stability to support children in the way that she would like.

Observing those individuals or settings is important but is not the only activity and it is not, therefore, an intervention in and of itself. As we'll talk about shortly, observation is one tool used in concert with other means to gain understanding and then to translate that understanding into action.

Let's then turn not just to what we don't do but to what we do. How does early childhood mental health consultation support the well-being of all in a setting, children and adults, while simultaneously attending to what might be considered acute mental health needs of specific children and families. I've listed the range of activities here, but I think and want to focus there more heavily on the central activity and what I see as the crux, the place where change happens. That is in the consultation meetings, the meetings between the mental health consultant and providers of care, teachers, family advocates, managers, administrators.

Predictable, even if periodic, consultation meetings are essential to the practice. We want to carve out protected time for these discussions, meaning that when we enter as mental health consultants into a Head Start center, part of the beginning partnership agreement or arrangement is to figure out how we will partner together to ensure that there is time to meet, which I recognize meeting time is sparse even for those staff who are in a center. Sometimes meeting is a goal, not a given, and part of what we work on developing in the beginning of our partnerships with a Head Start program.

These consultative meetings and the conversations that happen within them, though, are informed by our observations. To speak a bit about why we observe, what we observe, the frequency and timing of observations of either a particular child or classroom are based on several factors. One, observations are undertaken only with parental permission when who is being observed is an individual child.

I think optimally, not just having gotten blanket permission to observe but preceded, observations being preceded by the consultant having introduced herself and the service to the child's parent or caregivers so that then when we engage the parent, which we obviously need and want to do in order to understand the meaning of the child's behavior, they will be familiar with and already feel properly included in the endeavor.

Also, observations can only offer valuable information if the purpose is really clear and mutually agreed to by both the providers who are asking for consultation, or asking for observation for a particular purpose, and the mental health consultant. As mental health consultants, we want to speak with providers and parents about what would they like us to observe. What are they hoping that we will see? And even then, observation is only one avenue of understanding.

If we want to develop a complete picture of a program or a classroom, or a child, that depends on really eliciting from those who know the child, the family, the program best, which would, of course, include parents and providers. It's our ability as consultants to elicit from and then integrate our understanding that we gain from parents, providers, and observations into an action plan into co-creating meaning.

When we synthesize all of the understanding and information that's come from the important experiences and people in a child's life, then we combine these sources of knowledge and we co-create strategies to support the children and families. In instances where a child or family's needs exceed the interventions, the strategies that are developed for the classroom setting or for the home visiting setting, when the family's needs exceed that, then the mental health consultant has another role. That is that we can assist, obviously in tandem with others in the Head Start system, we can assist in securing appropriate resources.

With permission, parent permission, family permission, we can act as a liaison between the services that we have secured and the Head Start provider. Why? So that all of the adults in a child's life are working to form a cohesive net around the child and family and support them.

Last, but definitely not least, a mental health consultant meets with program administrators, site supervisors, and managers. Meeting with people at all levels of the system is aimed at promoting practices that support system health. You'll remember that I said at the beginning, part of the elegance and efficacy of the practice is that it works at multiple levels. We want to make sure that all levels of program are receiving consultation and working in concert with one another.

Early childhood mental health consultation's effectiveness is in large measure coming to be seen as making a difference because of promoting provider well-being. It's an intervention aimed at adults on behalf of children. What does this mean? It means that we have to intervene and understand in the stresses and pressures and strains that can interfere with providers being able to provide care as best as possible or see children and their needs as clearly as possible.

Promoting provider well-being and addressing stress is, in my opinion, or should be, an explicit intention of early childhood mental health consultation. Luckily, my opinion is starting to be supported by empirical evidence, for those of us who rely on research. We know that the work of caring for groups of young children and vulnerable families is incredibly stressful. Often, job stress is exacerbated by financial and familial and societal strains. Of course, what we all are aware of is that these pressures have been doubled during the pandemic.

Whether because of stress caused by COVID or tensions that preceded the pandemic, those in the child care profession have among the highest rates of physical and mental health concerns, even when compared with others in the same income bracket. We're also sensitive to – and studies have substantiated the powerful impact on children's … When adults emotional well-being, their attitudes are compromised, that has a huge impact on how they see children and how available they can be to attune or regulate or support children.

Teachers who report the greatest depression and job stress also tend to be the teachers who identify the highest level of problems in the children that they care for, understandably. When you don't have enough energy, lots of things that otherwise would feel manageable, some suddenly feel untenable. Teachers who are most stressed and depressed are also more likely to ask those children who they experience as challenging to be removed or expelled.

Conversely, teachers who participate in early childhood mental health consultation describe, from their own description, describe decreased stress and are less likely to rely on harsh discipline or expulsion as a way of remedying their own tensions. This is not to say that there

aren't children with extraordinary and idiosyncratic needs that need to be attended to. It is to say that we need to pay equal attention to the providers' abilities and what is compromising those capacities.

When you're stressed, any of us can attest to, when you're highly stressed or depressed, it's also hard to feel that anything you do matters. Many teachers describe feeling ineffective, especially in addressing challenging behaviors. From my own experience in running a program of mental health consultation and when we did a process evaluation, we asked teachers … One of the measures that we used was to look at teacher self-efficacy.

What teachers told us in response to a teacher self-efficacy scale, prior to receiving mental health consultation, is that most teachers – and this was way before the pandemic – most teachers that we surveyed said that they felt like nothing they did in that often eight hours a day, five days a week with the children in their care made a difference to who those children were.

Obviously, untrue. But if you don't see yourself as having an effect, why would you be invested, try new strategies, want to think deeply or change your behavior in relation to children or your program practices? Early childhood mental health consultation has been shown to boost teacher efficacy. Feeling like you will have an impact, I would suggest, is really essential for all of us and it's a real precursor to changing our perspective and eventually our behavior, and that includes teachers as well.

Mental health consultation in these ways also helps us to increase sensitivity and reflective capacity. As I said, this is a capacity-building endeavor. We want to think about whether we're aiming our efforts at the place where adult, teacher capacity, administrator capacity can be enhanced.

Research is also confirming that the quality of the relationship that we as mental health consultants develop with those we consult to is actually the most significant predictor of those teachers' sense of us having a positive effect. That what we do, how we treat teachers, how we show respect for their experience, how we help to diminish their stress, how we attune to their needs, in turn, goes far to their ability to attune to the needs of children and to have positive outcomes for children in their care.

This relationship, this positive relationship seems to have special meaning when the focus of consultation is a child of color. In research done by colleagues at Georgetown, Annie Davis, and at the Indigo Cultural Center, Eva Shivers and her colleagues, found that the quality as described by the consultee, by the teachers, by the family advocates, that the quality of the relationship that the consultant and the consultee have had a significant impact on outcomes when the child was a child of color.

The more positively the teacher perceived her relationship to be with the consultant, the more positively attached she became to the child who was the focus of consultation, and the more she said she felt able to understand that child's state and to persevere in caring for that child, the more interested he or she, teacher, was in thinking about new strategies and incorporating the consultant's knowledge.

Also, I want to say that the consultant's capacities also mattered. Consultants, White consultants and/or consultants of color who said, who reported that they engaged in study and self-examination, specifically related to equity and racism and practices of anti-racism, rated themselves as having high competency in culturally-responsive practice. Those mental health consultants were the ones who were viewed by teachers as better partners.

In turn, the child of color on behalf of who that collaboration was taking effect benefited. Racial or ethnic matching between the teacher and the mental health consultant bolstered these positive, these beneficial outcomes. These results, of course, suggest that an explicit equity focus and racial sameness exponentially enhance the effectiveness of mental health consultation in addressing the racial injustices that we know continue to exist in all of our institutions, but specifically in our early care and education institutions.

What are the factors that go into the formulation, the formation of an effective consultant-consultee relationship? Well, the studies I just cited are identifying some specific components, of what I call comportment, of our way of being as mental health consultants, how we bring ourselves. Here you see some of the characteristics as described by the consultee. The consultees said, when we asked about their opinion, how they were doing, what mattered to them, how they saw this child and really took that into account in our work, that made a difference.

That we communicated clearly and were able to hold the varied viewpoints about a child or a sticky situation between co-teachers, that we could hold varied viewpoints without siding with one or the other and lean into difficult topics around what were disagreements between providers and parents or inter-staff conflict, and that we could, with those consultees, find common ground. That's what made the relationship powerful and in turn, the outcomes for children and families better.

Of particular importance was noted by these teachers what I would refer to as an absence of hierarchy, meaning that we didn't promote a power differential, that we contributed our expertise in early development and in mental health, we contributed it, but we contributed it in a collaborative manner. Identifying the collaborative relationship was the primary predictor of beneficial outcomes. Positive relationships between a consultant and a consultee were repeatedly described in egalitarian terms, like the consultant was a team player. I felt like they were my partner.

If we think about, how do we interpret all of these findings? I would suggest that taken together all of the studies I just cited and my own anecdotal experience and, I hope similar to yours, point to the fact that without a perceived positive relationship, our good ideas and expert advice, no matter how brilliant or accurate as mental health consultants, are only minimally impactful.

If we think for any of us, whose suggestions do you try to incorporate? What makes you likely to want to change or develop your behavior in different directions? For any of us, I would say it's when we feel valued, understood for our limitations and our possibilities. That's what providers are telling us, is that even when the content expertise of a consultant is cited in some

of these studies, and in my experience, as important, it's also the manner in which the information is conveyed that's significant.

If we pronounce that a provider should be doing something different with a child rather than inquiring about how our ideas, about what might be put into place, land, how feasible they are in the context of caring for 20 other children, that's what registers as important and eventually impactful.

While I hope it's reassuring to be reminded that what matters most in our consultation is the way we engage – the way we engage with those we consult to. I wanted to take a minute to say I don't mean to imply that knowing, that expertise is not important to the practice. Also want to recognize there are many ways of knowing. There are non-dominant ways of knowing, traditions that Indigenous peoples have had for thousands of years that constitute knowledge. There's also what we refer to as evidence-based knowledge.

Expertise is, in an extensive range of things, essential to our effort. Early childhood mental health consultants need to be well-versed in development in all of its vicissitudes, from the perfectly common expectable things of young children to the entirely unusual. We need to know a lot, not only about early development but we need to know a lot about how adults learn, how they grow, and how they change. As I've just hopefully given you some sense of that given this indirect intervention is through and aimed at, and with adults, thinking about how adults learn and change and knowing about that is vitally important.

Beyond adult and child development, we have to be familiar with systems and organizational structures, organizational psychology and knowledge of that lends a lot to how we can bring ourselves and what we can bring. Understandings of philosophies of pedagogy, different ways that children learn, anti-bias curriculum. These are all essential forms of knowledge. Competency and understanding and addressing historical and contemporary trauma, if it's not enough, of all of what we need to know as mental health consultants, is essential.

These, and even other essential competencies, have been articulated by the Center of Excellence for Infant and Early Childhood Mental Health Consultations. I hope that you will go in further depth – the link is here and will be given again at the end and in the resources – to explore those competencies. There's also at the Center of Excellence website, there's a consultant assessment to help you think about and have a more codified way of seeing where are the areas that any one of us might benefit from more self-reflection, as well as gaining of more knowledge and information.

Given that I've talked so much about who we are as mental health consultants and how our positioning matters, I want to spend the last portion of time today, before turning to questions, introducing a framework for developing this kind of way of relating, this way of being, the kinds of consultative alliances that are proving to be at the heart of effective consultation.

I refer to this as the consultative stance. It's a framework that was developed by my co-author Charles Brinamen and I in a book that we wrote on mental health consultation. The phrase refers to who we are and what we bring. I think my colleagues Jeree Pawl and Maria St. John in the 1990s said it best when they said, "how you are is as important as what you do." That's

what the consultative stance relates to. We're inferring that it's our ability to empathize with and establish positive relational processes that is integral to the efficacy of our interventions.

For the last little bit, I'd like us to turn to that. There are 10 elements in the consultative stance. We won't be able to go through in depth all of them. Many people spend years, some of us a lifetime, embodying, practicing the consultative stance. I hope this will be an introduction that will intrigue you and that you will explore more. The 10 elements are listed here, but a few that I'd like to spend a couple of minutes on is the first, which is parallel process.

What is parallel process? I will, again, quote my mentor and friend Jeree Pawl who said, "Parallel process, for those of us in mental health work, is the platinum rule." What she meant by that is that we all, or most of us, grow up knowing something about the golden rule. And the golden rule is "Do unto others as you would have them do unto you." By saying that it's the platinum rule, what Jeree was referring to is this, is there's even a higher order rule. And what she described as the platinum rule is "Do unto others as you would have them do unto others."

As the studies that I just cited and as the graphic that I have here suggests, is that the ways that people are treated – in this instance meaning the adults in children's lives – the ways we as mental health consultants bring ourselves in a stance of curiosity, respect, a way of attunement, that how we bring ourselves to the adults in children's lives will go far to how they in turn can attune to, respect, show curiosity around the children in their charge. This is what we want to demonstrate in all of our actions.

One of the other few that I'm going to touch on elements of the consultative stance is one I refer to as wondering, not knowing. What I mean by that is that wondering with another, with the teacher, with the parent, with our consultee, wondering with, not acting upon the providers with whom we are consulting has many benefits. First, it elicits their involvement in the process.

It says, it conveys when we wonder with somebody about what their perception is, what they've already engaged around with the child that they feel like works or where they feel like things have fallen short, where they're puzzled or where they found strategies that promote possibilities, what it does is it not only elicits their involvement, but it properly preserves them, the adults who are directly involved with the children, preserves their sense as the agents of change. Any advice we may offer is only as good as the providers' and parents' ability to enact it directly with the child.

Also, pondering together demonstrates to the consultee that understanding a complicated inter-staff situation or understanding a child who behavior is perplexing or exasperating or concerning, that understanding is a process, not a moment. We don't know what to do about a child who's biting the first time we see that child, or hopefully we don't think we know what to do until we've understood with all of the adults in that child's life and maybe through our own observations what's contributing to it, what the child is expressing through their behavior.

Asking the adults in child's lives, asking elicits the providers' or parents' currently held ideas about why the child is behaving in the way they are or why a staff situation is going the way that it is. Often, the way that behaviors are labeled immediately assumes we know the cause.

For example, a child who cries constantly and can't nap without a constant comforting is labeled initially by their teachers as spoiled. What it does is it locates immediately the cause of the behavior, as primarily with the parents. These immediate assumptions stop our search for other causes, and they can preclude providers and ourselves as mental health consultants from imagining what are other possibilities, or imagining that anything we do would have an impact.

We also through wondering, are hoping to ignite or engage the curiosity of the provider in understanding obstacles to change or thinking that there are multiple reasons, multiple perspectives for the behavior that they might be seeing or stressed by.

Successful consultation relies on the consultee's capacity to reflect, to think about, as well as to generate expanded notions of causality. What happens when you ask the question, as I just did? If we can register that when someone asks a question out of genuine curiosity, not coercive or interrogation but with genuine curiosity, what happens whether for a nanosecond or for hours is that we begin to reflect.

I said in the beginning, one of the capacities that we are trying to enhance or support or expand in providers is the capacity to reflect, to reflect on the meaning of their own behavior, to reflect on the meaning of a child's behavior, and to strengthen the reflective muscles that can collapse under stress. Through these seemingly simple exchanges, the consultant can respond to a provider's emotions, to their internal representation, and it elicits reflection and possibly new ideas about the meaning of a child's behavior and how we could successfully collaboratively address it.

The next element of the consultative stance that I want to highlight is called hearing and representing all voices. This element really speaks to the need to attend, not just to an individual provider's perspective but to attend to the myriad relationships on multiple levels in the Head Start community to which we are consulting. While we, yes, want to hold each provider's perspective, we also want to make sure that all the members of a child care community's perspective are heard and valued by us as the consultant, but also heard and valued by those with whom they work.

We demonstrate this through both our empathic inquiry and our calming, hopefully, comportment that we demonstrate that different points of view are not only expectable but they're enriching. When two providers, for instance, hold diametrically opposed ideas about the meaning of a child's behavior, saying, he never does that when he's in my care or he always does that in the afternoon but never in the morning, we want to convey intrigue and curiosity about that difference in perspective, not a who's to blame here or let's get to the truth of who's right attitude.

We might posit even something like, wow, this is fascinating. What are the two of you think accounts for you seeing the same child in such a different way? The consultant is demonstrating that various views can be held and heard equally, and that they all contribute to greater understanding of a child or a situation.

I want to end our time with concluding with what is actually also the final element of the consultative stamp, and that is the element of holding hope. Providers again, even before the last almost three years of the pandemic, providers often lose hope, lose hope in the face of

daily challenges and what feels like persistent crisis. The increased pain and pressures of the past few years have, of course, exacerbated that sense of helplessness and hopelessness.

We as mental health consultants are the ones who, I would suggest, must – not that it's easy. We have not been immune to the pressures, the losses, the difficulties of these past few years or before. We are the ones who work to maintain our belief, our belief in change, our belief in positive future possibility in what are, of course, slowly shifting system.

The consultant can also hold hope for, not just with, but for the consultee or for a parent who seems to have lost hope. Because most often, not always, but most often, the consultant is the one who has the luxury of stepping out of. What I mean by that is while there's different positioning, some consultants are employed with and embedded in a Head Start setting. When we have the positioning of both literally and figuratively, stepping outside the hierarchy of a system, stepping outside into fresh air, stepping outside of a seemingly static and stress-filled system, that perspective allows us to see more possibilities.

I often think about it – and I know you probably can't see me in my tiny little box, but I'm holding my hand right up to my face. I often think about it analogous to this, is that we don't always see most clearly by being so close to something. Sometimes a pulled back perspective, which does not mean disengaged or absent, but a pulled back perspective allows us to see and offer possibilities of hope.

I'd like to leave us then because we need hopefulness, just like all those we consult to, is that I'd like to end for the moment with a quote by Rebecca Solnit who said, "Hope locates itself in the premise that we don't know what will happen. And in the spaciousness of uncertainty is room to act." The last few years uncertainty has become associated with anxiety, with loss, with trauma, and wanting to reopen the space where not knowing, wondering, reflecting. Actually create space in ourselves, in others, in a system where we can see and respond to each other more clearly, more compassionately, more effectively.

Before we turn to the questions that I hope you have, comments I would love for you to share, I want to draw your attention to one more slide with links to a few resources. A few of them I mentioned in the context of the presentation, of free resources where you can obtain additional information about early childhood mental health consultation that I hope will be of interest to all of you and especially those of you who engage deeply and daily in the practice of mental health consultation.

Want to thank you, all of you, not just for your time today but for your engagement in the very important and essential practice of mental health consultation. Now if we can turn to questions. I see that my colleague and friend Amy Hunter has joined me on screen. For those of you who maybe missed at the beginning or need a reminder because it seems like ages ago, Amy is the co-lead of the behavioral health portion of the National Center on Health, Behavioral Health, and Safety.

Amy, thank you for joining me. We do this back and forth of questions and thinking together in a regular way monthly when we provide a once a month, which is happening on Monday, once a month office hours on mental health consultation for those providing and/or interested in mental health consultation in Head Start, which I hope you all have received the eblast about it,

starting up again after a one month hiatus on Monday. Pleasure to be joined by you, Amy, and to wonder about what people's wonderings are.

Amy Hunter: Yes. Well, we have two excellent, big, good, juicy questions.

Kadija: OK.

Amy: Before we dive into them, I just want to thank you again. Kadija. As Kadija mentioned, we are together once a month at the office hours. If folks liked what you heard today, there's more every month. You can ask questions each month. Please, do join us for those office hours on the last Monday of the month.

Kadija: That's right. That's right. Unlike today – more of what today is, but unlike today, really asking, literally people to bring their current conundrums, their pressing questions, what you're thinking about right now in mental health consultation. Amy, what were some people thinking about right now?

Amy: Well, lots of questions in the chat now that we mentioned the office hours about how to access them. When I'm done with this verbal question to you Kadija … Oh, look, Nydia already put in the chat. Great job.

Kadija: Thank you, Nydia. Thank you.

Amy: All right. We have information about the office hours in the chat, but here's the first question that came in. I have to admit, when I read this question, I had one thought in my mind. As I sat with the question, my thoughts really evolved. I know Kadija knowing you, you are going to give a beautiful, complex answer to this complex question. The question is that they – I'm going to summarize it a little bit.

That there is a manager in a program, a mental health manager in a program and she is discouraging the idea that the program has. This idea seems to be supported by a mental health consultant outside of the program. The idea is that they want to develop a new sensory room where, at the site, they would remove children with problem behaviors or children who are having big emotions and the wording is sending them to the sensory room. This person who's writing the question is discouraging that practice for a variety of reasons and she just wants to know your thoughts about this and how you would handle it. I think it's such a rich, complex question. I'm curious.

Kadija: Thank you to the participant. Interestingly because I feel like this type of question – and by that, I mean a question about a particular immediate situation is exactly the kind of question that often gets posed and taken up at the office hours. Like there, I will hope that my answer, albeit abbreviated, will be of use to the person who asked the question and that the ways that I think about the question will be applicable to all of you. My wish will be to generalize and to reference how some of the concepts I presented could most be employed.

What comes to mind for me is that the ways in which we can get into tangles. What I mean by that is that by any of us, a mental health consultant, a parent, a manager, a teacher, the way we can get into tangles when we are only able to have a single source of information and not able to think together – again, this idea of time in meetings – to really think together about why do people hold the views they do?

I would hope that mental health consultants would be really interested, in this particular situation, interested in the asker of this question's ideas about why I can infer the idea is that it feels like it is sending children away, it's removing them. It feels like – it is felt to be a punishment and that what we want to think about through – as mental health consultants, through wondering about different people's perspective is to come to understand, not just the meaning of those perspectives but really to think about is there a way to get the valuable essence of – like in this person's question. Of course, I'm inferring and would want to know much more.

A way of being able to say it's so important that you're thinking about children not feeling separated or labeled or pulled out. Is there a way that we could think about meeting children's sensory needs, which is what I'm assuming the sensory room is for? Is there a way of meeting children's maybe extreme, maybe intense sensory needs in a way that doesn't lead to them feeling extruded or bad or problematic?

Because any intervention that is going to be most useful, one, needs to be endorsed by everybody involved, not just one person. It needs to address these very, not only opinions but needs to address the very experience, varied experiences that children might have. Really appreciate how can it be that these varied perspectives of – as I talked about in one of the elements of the consultative stance – that the varied perspectives are held and represented and heard together as we enact what we all would hope would be a beneficial practice for children.

I'm also interested, Amy, if we have any time, what was your response? Or maybe we don't have the time. I'm sorry. I know we have to probably end.

Amy: Well, I do think we, unfortunately, have some more questions that we don't have time to answer for today. Just I think I would piggyback on your answer to say there's a lot of really interesting information out there about the sort of benefits and the concerns around that kind of practice. I love, of course, the way that you're thinking about holding people's values and opinions and concerns, and having robust discussion about all of that amongst the team.

Kadija: I love what you bring in, Amy. It's perfect. Because right then I said, and there needs to be knowledge and information. We then want to bring in additional knowledge and information outside of our own experience. Thank you, Amy.

Amy: Yeah.

Kadija: All right.

Amy: Well, Thank you Kadija. Thank you all for joining us today. As Kadija said a couple of minutes ago, thank you for the work that you do in an ongoing way for children and families and staff. It's a tough time these days in this important, important work. What you bring is incredibly valuable. You want to turn it over to Nydia for our …

Kadija: Yes, please. Nydia. Yeah. Thank you, Amy.

Nydia: Thank you. Thank you so much to our participants. Thank you again to Kadija Johnston. Thank you, Amy, for hopping on and helping with those questions. Such great, thoughtful questions. If you have more questions today, you can go to MyPeers or write to

health@ecetta.info. The evaluation URL will appear when this webinar ends so be sure not to close the Zoom platform or you won't see that evaluation popup.

Remember that after submitting the evaluation, you will see a new URL. This link will allow you to access, download, save, and print your certificate. You can subscribe to our monthly list of resources using this same URL. You can find our resources in the health section of the ECLKC or write us at health@ecetta.info. Thank you all for your participation today. And Kate, you may close up the Zoom platform.

Kadija: Thank you. Bye, bye everyone.

Nydia: Bye, bye.