Building Social Emotional Health

CASE STUDY AND EVALUATION OF AN ONLINE COURSE

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Acknowledgement

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Background

"Building Social-Emotional Health as a Foundation for Success: The Unique Role of the Child Care Health Consultant (CCHC)" is an experimental course. Initially, Docs for Tots director Dr. Dina Lieser sought to develop existing slideshows into a series of 2-3 video tutorials with quiz questions, addressing an audience including CCHCs, child care providers, center administrators and parents. A shoestring budget cap had been set for this purpose.

Dina found Bram Moreinis (an instructional design student at UMass/Boston). Though willing to do the work, Bram's opinion was that the scope and depth of information contained in Dina's slideshows, though comprehensible by professionals, would not be conveyed through passive viewing enough to accomplish Docs for Tots advocacy mission of changing attitudes and practices.

Instead, Bram proposed that the project be re-conceptualized as a fully interactive online course, designed to develop a Community of Inquiry among narrower student cohorts beginning with CCHCs. Bram proposed using of a broader set of multimedia, interactions, and activities to deepen CCHC knowledge and attitude transfer through engagement, communication, and collaboration in an LMS environment, supported by rich content and interactive tutorials.

Bram offered to design, co-develop and co-deliver the project pro-bono, in return for Docs for Tots development and delivery support. His offer was accepted, and support was provided by subject matter expert Emily Leone, who participated as co-developer of presentations and co-instructor, with program support provided by co-director Dr. Liz Isakson.

Bram, Emily and Liz collaborated over three months of weekly online development meetings, conducted via Google Hangout and supported by Google Drive for collaborative document development and Camtasia for recording and editing of Emily's lectures.

"Building Social-Emotional Health as a Foundation for Success: The Unique Role of the Child Care Health Consultant (CCHC)" was advertised to a contact list of New York State CCHCs as a "free, interactive online course … to build capacity in the promotion of social emotional health in the child care setting." No professional development credits could offered, so prospective students would need to be sufficiently motivated to devote 15-20 hours over the summer to an experimental course, relying on learning technologies many were unfamiliar with.

Prospective students were contacted through list serves supporting CCHCs in New York State. These emails linked to a preliminary syllabus, and a registration form with a two learner survey questions about professional background and experience with online learning. Requirements for the course were stated as follows:

> Participants should expect 2 hours of course work per week and be practicing Child Care Health Consultants in New York State. Three weeks of the course will have live video conferences that will require a specific schedule."

Emily had established relationships with many of the CCHCs that are "early adopters" and likely to sign on to do a 6-week course, considering a move to online learning as an extension of that relationship. Nine students registered, and of these, seven completed the course. What follows is a description of the course design, the learning community interactions that took place over 7 summer weeks in 2014, the course management patterns, and a summary of participant pre- and post-course surveys.

Course Design

Audience Analysis

Based on job postings, Docs for Tots reports, and research (Ware, 2005), the focus of the training audience was determined to be NY-based Child Care Health Consultants, mostly women between the ages of 22 and 68, median age 48. Expected educational levels were mostly undergraduate degrees in nursing, with a third at Master's level, and a few doctors. Health consultants have skills and competencies beyond entry level health professionals. Many spend their workdays traveling to different centers, and use email and the web. Some have taken virtual coaching webinars, and all have had online access to SME Emily Leone through previous trainings or online list serves.

Based on this profile, it was determined a variety of training modalities would be preferable to sole reliance on narrated slideshows for content and skill acquisition, and that learner participation in developing knowledge resources and job aids (in this case, a Wiki) would be preferable to post-slideshow quizzes for checking for understanding, supporting knowledge retention and skill transfer.

Ten students registered for the course. Of these, eight were certified medication administration trainers (MAT). Two had taken many online courses before, but this would be the first online course for three, the second for five. This population matched the expected learner characteristics. For the three students new to online learning, extensive one-to-one technical support was provided on demand, in addition to an orientation week designed to acquaint new users with Moodle (the course LMS) and the course model.

One student, Kim, serves as the Health Consultant for New York City's Administration for Children's Services, Division of Early Care and Education, and brought a deep, critical perspective to the course.

Course Goals

In the promotional email, the course promised to increase participating CCHC abilities to support social emotional health in infants and toddlers (ages 1-5), in three ways:

1. **Conveying information and advocacy** (including current research and childcare standards and their importance for individuals and society, which had been the goal of narrated slideshows);
2. **Training in functional applications** (improving the guidance and linkages CCHCs offer child care providers who seek assistance with challenging behaviors and classroom difficulties, supported by the interactive model of the full online course); and
3. **Building connections with colleagues** from around the state, leading towards a network of Health Care Consultants (building a Community of Practice, for which this course was positioned as a potential seed, taking Moodle discussions to a new Docs for Tots list serve).

In the course syllabus, performance goals for learners were stated as follows:

1. Analyze observed interactions for patterns that support or block social-emotional development, including serve-and-return, temperament, and causal models for behavior.
2. Build consultation plans supporting social-emotional health appropriate for each of the 9 visit contexts and 5 roles CCHCs play with childcare providers and others.

3. Identify and commit to new ways to support social-emotional development in the workplace.

In addition, the course's final project was described: "[L]earners will work in collaborative groups to build a consultation plan from a provider case study which supports social-emotional health."

Course Objectives by Week

The course was scheduled for six weeks of content delivery, with a preparatory orientation ("Week 0") to the course technology, design, instructors and students. Course learning objectives for each of these weeks were as follows:

Week 0: Course Orientation

1. Participate actively and effectively in the LMS.
2. Establish communication channels and roles among trainers and peers.
3. Navigate between the Moodle tools and Captivate tutorials.
4. Develop and share an online presence by completing a profile.

Week 1: Foundation for SED Built In Early Childhood

1. Define Social-Emotional Development and describe how it unfolds in caregiving relationships.
2. Reframe disruptive behavior as indicative of low Social-Emotional Health, a medical concern.
3. Identify connections between low SEH in childhood and future individual and social impacts.
4. Describe how experiences and relationships in early childhood impact brain development and thus the capacity for executive function.

Week 2: The Child Care Health Consultant's Powerful Role

1. Describe the unique role, access and potential of the CCHC to positively influence SED.
2. Understand how four key CFOC standards promote practices that support SED.

Week 3: Supporting Relationships

1. Identify ways CHCCs can help providers create and maintain relationships with children that support SEH as described in Standards 2.1.2.1, 2.1.2.2 and 2.1.2.3.
2. Recognize the role of emotional literacy in providers in helping children understand what they and others are feeling, and why not to hurt others.
3. Describe how infant/toddler behavior and communication is meaningful.
4. Analyze the quality of observed child/provider interactions in infants.
5. Analyze the quality of observed child/provider interactions in toddlers.

Week 4: Responding to Disruptive Behavior

1. Identify disruptive behavior as a chief provider stressor.
2. Relate the influences of provider stress and their framing of disruptive behaviors as opposition to provider capacity to support SED.
3. View disruptive behavior as a function of a child's needs to provide leverage for different responses.
4. Consider interventions to suggest to provider in response to background information.

Week 5: Consultation Planning

1. Analyze provided information to plan for a scheduled consultation.
2. Use resources provided as frameworks for analyzing situations and preparing consultation plans.
3. Develop a consultation plan in collaboration with other CCHCs.

Week 6: Exploring a Community of Practice

1. Consider collective next steps.
2. Initiate network-building activity by posting to discussion forum and replying to posts.
3. Evaluate the potential for network building with other consultants and reach out.

Instructional Activities

The key difference between sole reliance on narrated slideshows and the affordances of online learning is the potential for active learning through discovery and application. Whenever possible, course activities were modeled on functions required in the CCHC's performance environment. To develop a Learning Community, activities were designed to move learners towards greater degrees of online collaboration, culminating in the final project.

Each week ("module") began with a narrated slideshow and/or screencast, either by Bram (regarding course design and technology) or by Emily (regarding course content). Activities emphasized active learning strategies (conference calls, video analysis, explaining content to proxies, case study analysis) to engage learners and appeal to differing learning styles.

Content increased in detail to deepen content knowledge, from narrated slideshows to job aids that included checklists ("SED Pledge", "Vital Signs"), procedures ("Consultation Planner"), and detailed guides ("Mental Health in the Child Care Setting"). Degrees of document collaboration followed suit, from Forum posts and comments to shared Wikis ("SED Pledge, Reframe Wiki"), from individual to collaboratively developed consultation plans based on case studies.

Learning activities were as follows:

Week 0: Course Orientation

1. Participate in a telephone conference call with simultaneous Moodle-based chat and video.
2. View a series of narrated screencasts and tutorials about the online course design, and preparing for three individual tasks (customizing the user's layout for simplicity, taking a screenshot to facilitate potential technical support needs, and posting this to the Q&A forum).
3. Use an online tutorial to assess readiness to participate.
4. Perform the three operations.
5. Create an online profile, with an uploaded photo or avatar.

Week 1: Foundation for SED Built In Early Childhood

1. Learn how to create a Moodle Wiki, formatted as a "Know - Want-to-Know - Learn" (KWL) chart.
2. Add one entry for each column, based on the week's topic.
3. Watch the content video, and update the Wiki.
4. Watch a recording of Liz telling a provider what she understood from the content video, looking for three mistakes she made in her understanding.

5. Enter the three mistakes in a "Find the Flaws" form.
6. Develop an error-free script for telling a childcare provider about the video content.
7. Find a provider (or stand-in) and, from memory, convey this content.
8. Report on the experience of conveying the content in the Student-to-Student forum.

Week 2: The Child Care Health Consultant's Powerful Role

1. Brainstorm connections that CCHCs can make to support providers (via live chat / conference call) with follow-up on Student-to-Student (S2S) forum.
2. [Methods are recorded by instructor onto Wiki]
3. Watch Screencast about effective connections ("Ways that Work").
4. Comment further and add to S2S forum. [Instructor updates Wiki as "SED Pledge"]

Week 3: Supporting Relationships

1. Watch Week 3 Screencast about 3 CFOC standards for Supporting Relationships.
2. Look over Vital Signs of Supporting Relationships - this is a **key resource**.
3. Watch video footage of Provider / **Infant** interactions and pick one.
4. Analyze quality of observed **Serve & Return (S&R) and other behaviors.** Use the Vital Signs Checklist for Infants or just see what you notice.
5. Alone or in pairs (use Moodle Quickmail to communicate at first), compose positive feedback forum posts to give to the provider in the video about what she did right.
6. Watch video footage of Provider / Toddler interactions and pick one.
7. Analyze quality of observed supportive language and action and other behaviors. Use the Vital Signs Checklist for Toddlers or just see what you notice.
8. Alone or in pairs (use Moodle Quickmail to communicate at first), compose positive feedback forum posts to give to the provider in the video about what she did right.

Week 4: Responding to Disruptive Behavior

1. Watch Presentations and Provider Videos (Part I, Part 2) and view the Reframe Wiki
   - Identify provider stress as a contributor to disruptive behavior. Re-view first provider video for reference if needed.
   - Reframe complaints about disruptive behaviors (child's fault) as neutral statements. Re-view second provider video for reference if needed.
2. Wiki Activity I: Consider statements from video, or those heard in your practice, and add one Statement / Reframe to the Reframe Wiki.
3. Wiki Activity II: Video Analysis: Watch two videos of a disruptive child named Michael and choose one. Look for Provider Stress, Opposition. What could be contributing to the misbehavior? Add one more Statement / Reframe to the wiki, based on one of these videos. Use name (Michael) and video number (3.2, 3.5) so we know where it came from.
4. Case Study: Given presented case, upload a minimum of two response suggestions for the provider.. Use the "Think-Through Process" to provide initial guidance. You may work individually or in pairs.

Week 5: Collaborative Consultation Planning

TASK: Create consultation plans from provided background for an SEH support case study.

1. **Emily's Presentation**: Watch 30-second Introduction, then:

    1. Emily's comments on submitted work from Week 4 case study (Calvin).
    2. Emily's solution (see also Worked Example, solutions and what happened.)
2. **Work Group Consultation Planning**: Video Tutorial
    1. In pre-set groups of 2-3 (NYC, Upstate, Cross State), using a "Jigsaw" approach (each does a piece), read and use two resources, and with a shared wiki, create a consultation plan for the "Eli" case:
        1. Mental Health in the Child Care Setting
        2. Consultation Planner
    2. Use a Small Group Wiki to develop consultation plan for the Eli Case. This is shared as a Google Document. You can (if you know Google Docs), make a copy, share it with your group partner(s) and annotate it, OR copy and paste it into one of your group wiki pages for that purpose.
    3. When done (or for instructor feedback), submit your assignment.
    4. When you are ready for student feedback, post a link to your wiki to the Student-to-Student Week 5 Discussion Forum.

Week 6: Exploring a Community of Practice

1. Participate in Conference Call
2. Post to S2S Forum
3. Complete Exit Survey

Details for these activities are included in subsequent sections below. The course is open to guest access as well at http://moodle.empowered-teacher.com with the password "empowerme!"

Student and Course Evaluation

Because this course was offered free and for no credit, there was no expectation of grading or summative evaluation by an instructor, though rubrics were provided for complex assignments. Formative evaluation was provided through replies to all student forum posts, sometimes by commentary appended to a video about the preceding week, and through comments on written assignments. There were also three conference calls with Moodle chats that served as "check-ins" between students and instructor.

The model for this course was primarily students serving as exemplars to each other. Because the course took place over the summer, not all students were able to keep pace with each week, and at different times different students would be the first to complete work, inspiring comments and modeling work for others.

Students completed a summative evaluation of the course, discussed in the close of this document. Questions included:

1. Did you feel that the training met your expectations? (Likert)
2. Is there something specific that was not covered that you would have liked to have been? (Short Answer)
3. Do you feel better able to positively affect SEH in child care settings as a result of this course? List some ways, if so. (You can compose elsewhere and paste into this box if you like). (Short Answer)
4. Would you consider taking another CCHC online course? If so, what topics would you be interested in covering? (Short Answer)

5. How would you describe your level of participation in this course? (Enthusiastic / Full / Partial / Minimal)
6. Would you have preferred a personal, non-interactive format (watch videos, read materials, answer quiz questions on your own time)? (Yes/No)
7. This course followed this design:
    a. Initial engagement with the online tools, simple assignments.
    b. More complex assignments, more interactions with others.
    c. Deep assignments, with deep collaboration.

    How did you experience this progression? What do you remember working well, or not so well? How was the pacing? Was a 2-hour-per-week estimate appropriate for you? Please write whatever you would like us to know about the course design, to affirm what worked and inform future changes. This is where we really need to hear detail! (Essay)

Teaching Strategies

As co-instructors, Emily (SME and Content instructor) and Bram (Designer, Developer, and Technology Instructor) both employed the following strategies:

1. Live conferencing (via conference call and chat)
2. Video presentations (screencasts and narrated slideshows regarding content, course activities, and technologies) using Camtasia (combining the visual presence of the instructor with the prepared material to build instructor presence).
3. Forum posting and commentary. Forums included Announcements (instructor initiated), Question and Answer (student-initiated), and Student-to-Student (with topics tied to weekly activities, but with students able to initiate new discussions).
4. Assignment review and feedback
5. Group emails and individual email correspondence

In addition, Bram developed tutorials with Adobe Captivate to train students to use Moodle and to take screenshots, and also provided a Wiki-based FAQ, populated from predicted issues and from issues raised in the Q&A forum or via email exchanges with students.

The Syllabus was available for review during registration as a PDF. There were some small changes during the latter half of the course, but nothing substantial. The following week's activities were made available for students who wanted to look ahead. Emily, Liz and Bram collaborated on the development of original materials and the adaptation of found materials for this course. Beyond these, students were given no outside readings.

Interaction and Feedback

Interaction and Collaboration among Learners

Students became acquainted with each other through three live conferences and through forum activity. The effectiveness of course activities to meet intended objectives was revealed primarily through student posts and comments on discussion boards, until the final activity when students collaboratively developed consultation plans, presented them in a forum for comment, and discussed them in the final course live conference.

The course moved quickly from individual to group activities, in keeping with the instructional intent of forming a community of inquiry. In addition to weekly forum posts and comments in response to assignments, group and collaborative opportunities included:

Week 0:

- Icebreaker and Technology Orientation: Participate in a telephone conference call with simultaneous Moodle-based chat and video.

Week 2:

- Practice Reflection: Brainstorm connections that CCHCs can make to support providers (via live call).

Week 3:

- Video Analysis: Alone or in pairs, compose positive feedback forum posts to give to the provider in the video about what she did right.

Week 4:

- Wiki: Consider statements from video, or those heard in your practice, and add one Statement / Reframe to the Reframe Wiki.
- Case Study: Given presented case, upload a minimum of two response suggestions for the provider. You may work individually or in pairs.

Week 5:

- In pre-set groups, using a "Jigsaw" approach, read and use two resources, and using a shared wiki, create a consultation plan for the “Eli” case.

Week 6:

- Participate in Conference Call (sharing and discussing consultation plans, reflecting on course and next steps).

Interaction between Learners and Instructional Materials

Beyond forum posting, students used a range of tools to interact with course content, including:

- Group Video response (watching simulcast during live conference, then discussion).
- Prepared Video Analysis using a “find the flaws” Moodle Questionnaire.
- Content Presentation Video Response using a choice of audio or video recording, keyed text, or uploaded document.

- Documentary Video (Choice) Response using a wiki ("Reframe Wiki").
- Documentary Video Analysis using a job aid (Vital Signs) and a checklist (Questionnaire).
- Case Study Analysis using Wiki (or Word Processing Uploads).

After each of the first four weeks, Bram provided Emily and the other Docs for Tots team with a status report, describing student activity, and follow this with a group email. Emily would follow up individually with students who were falling behind in their work.

In the Week 0 orientation, instructors shared that because these students were volunteering their summer hours as beta-testers, there could be some flexibility around deadlines. However, it was emphasized that because of the group and collaborative nature of many of the assignments, and the limited duration of the course, all would be better served if students maintained pace.

In Week 0, seven of the nine registrants participated in the course. The two who did not were prevented by personal crises, which they shared about with Emily. By the end of Week 1, five students had completed their work, but three caught up in Week 2. For the duration of the course, an average of 5 students kept up with the work, with two catching up after. Two students dropped, citing time constraints.

Interaction between Learners and Instructor

Students took many opportunities to show appreciation for Emily's thoughtful replies to their posts. Emily strove to reply to any posts of substance, and the depth of her replies brought much content knowledge, which was more relevant because it was framed in response to their experiences. Here is an example of one of Emily's longest response posts:

Debbie- Wow! And thank you for bringing back these excellent questions from your experience. I am going to answer them in order as best as I am able to.

1) Is it a fad? No it isn't though the language may change some as it filters through the system from health professionals and mental health professionals to education staff. There was a very important study called "Adverse Childhood Events" or "ACEs" done by Kaiser Permanente and the NIH. They looked at adults who were sick and dying younger than a similar cohort of adults. They were sick and dying from what the health field would consider to be life choices. Drinking, smoking, drug use, obesity. What these people had in common was these so-called adverse childhood events. Things such as domestic violence, child abuse, neglect and/or sexual abuse, an incarcerated parent etc. Each of these ACEs would count as one. People with 4, 5, 6, or 7 ACEs had medical histories of smoking, alcoholism, substance abuse, heart disease, high blood pressure, stroke, etc. The short of it is, our governments, business leaders, and medical profession are VERY interested in how we can break this cycle and they see high quality child care as one of the ways to help or at least not cause harm.

2) Is there going to be training or in-services with practical ways to implement this? As I think you have started to recognize already, I don't think there is a simple, easy-button way to implement this. Excellent infant teachers like Janelle are few and far between. We'll be touching on this further in the course. I see it more as a practice change within the early care and learning field. So yes, there are resources- especially Infant/Toddler Specialists or Mental Health Specialists depending on where you are in NYS. And yes, it does take money. 4:1 infant:provider ratios make this type of care very difficult. The state is working on things like Core Body of Knowledge, Trainer Credentials, and Quality Stars NY to

standardize high quality care and infuse it into the field. But this is also where we come in. Using the big medical words and being a trusted health professional really makes an impact on some caregivers including parents. Letting them know and reaffirm that the seemingly little things that they do, cuddling, talking with and to babies, make a huge difference down the line in brain development and SEH.

3) The Quality Stars I mentioned above is a way to get those directors who are more concerned about the bottom line in line with focusing on quality care. The idea is that parents choose programs with 4 stars as opposed to a program with one star. The stars are earned through education, training, and implementing high quality practices that are measured using the ITERS-R or other rating systems. Programs with low scores develop plans to improve their programs and thereby improve the quality. A lot of the measures are closely related to what we are learning in this course. So yes, Directors can be punitive, but the thought is that it will be easier for them to adopt high quality practices since it will result in higher enrollment and happier children & staff.

4) I think I answered this one in number 3. I only think it can be effective if it is part of a change in the child care culture. Without a change in the field there will be isolated pockets of excellence, but the remainder of the field will be providing 'custodial' care. I think some of these changes are similar to what we saw in the 80s during the nursing shortage. Pay got better for nurses, so did respect. While it isn't all roses, we saw a big improvement. I personally think that a similar change has to occur in child care. The providers need to earn a living wage and the expectation should be for well-educated teachers that are respected for their expertise and skill.

I am going to double-back and get to Janelle's questions about children going in and out of high quality interactive rooms/environments. If you remember the kids in Romania who were raised in the orphanages with little to no stimulation. It didn't turn out great for those kids, but some amount of rehabilitation was accomplished. We, in general, are not talking about that type of situation here, but there are similarities. It is best for babies and toddlers to have their brain development occur in the best way possible for that child's genetic make-up. If that doesn't happen, rehabilitating and rebuilding the neural pathways can occur, but it takes more effort, more resources, and in reality more money. This is one of the reasons our special ed and school counseling services are so over-taxed. I refer back to the ACEs study. Therapy, counseling, and treating the medical conditions can help adults who have experienced the adverse events in their childhood, but wouldn't it be better (and cheaper) to break the cycle of abuse or whatever it is and thereby maybe not need the counseling, etc?

I hope this helps a bit, and really appreciate that you took this message out to an actual high quality infant teacher and brought back these great questions.

Emily

Interface and Content

Moodle LMS Organization and Aesthetics

Moodle, unlike Blackboard, does not present a Table of Contents at the left by default, but instead offers an array of navigation blocks. Because many of these students had used Blackboard for previous coursework, the Course Contents block add-on was used, and each week was given a number, topic title and date so that this block served as a clear index and mini-syllabus.

However, this added another sidebar block to the many Moodle presents to the new user, making the interface unnecessarily complex at the start of a course. For this reason, the first technology tutorial taught students to hide or "dock" the sidebar blocks, leaving only the Course Contents and Key Resources. In the image below, all other blocks are "docked" on the left side.

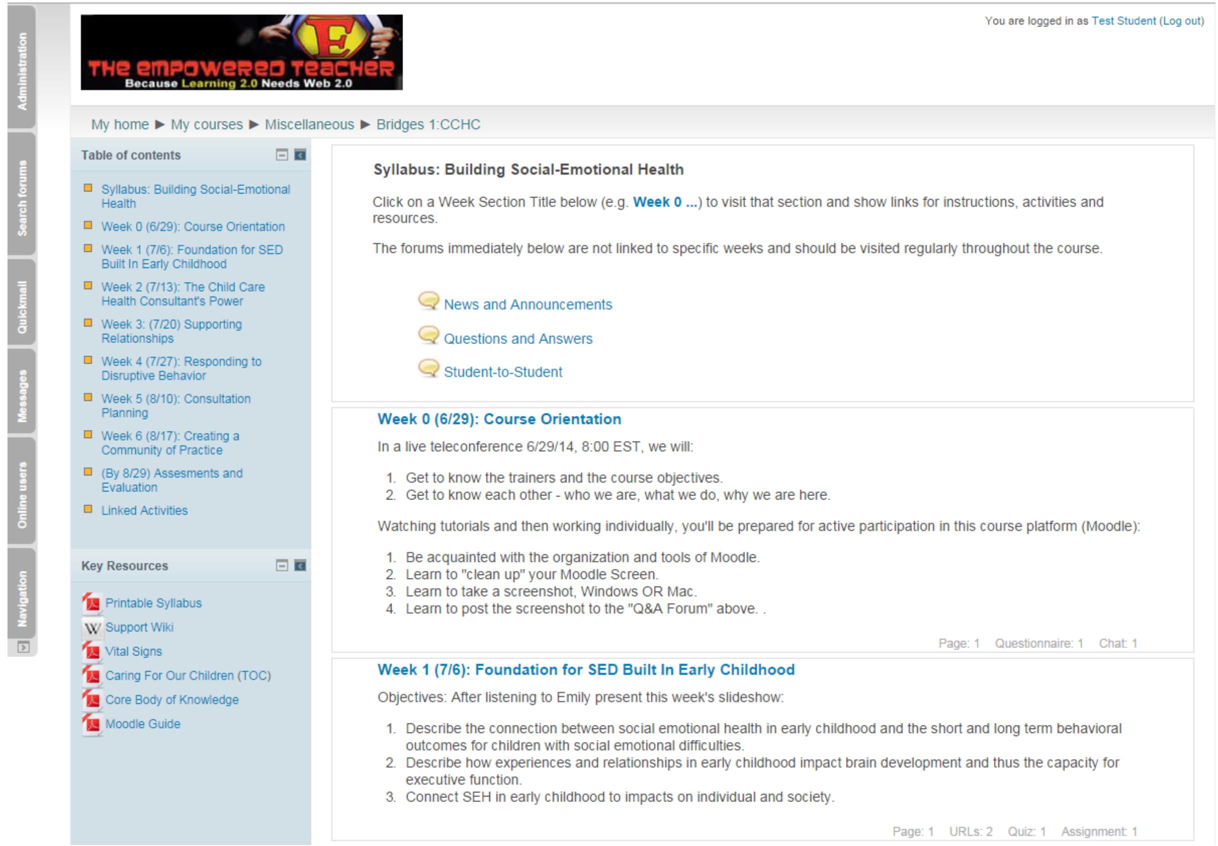


Figure 1: Simplified Interface

The image above displays Moodle's "Hidden Sections" configuration, where only the titles of each week were clickable, showing descriptions but no resources below. This option was chosen to limit the number of clickable options to present students with. On all pages, the three key forums – News, Q&A, and Student-to-Student – display on top, since they are always relevant. Below is a view of a sample week detail, viewable by clicking on a title:

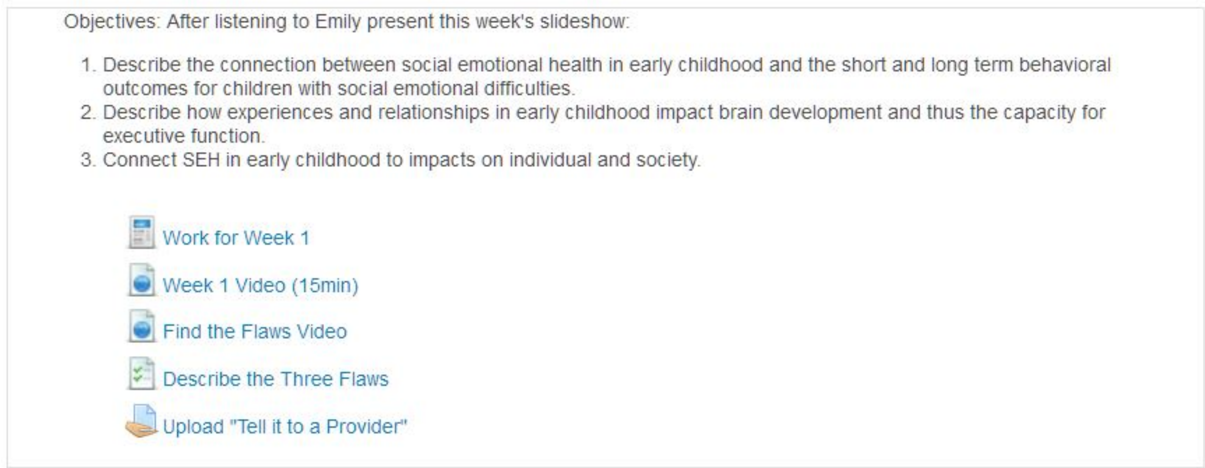
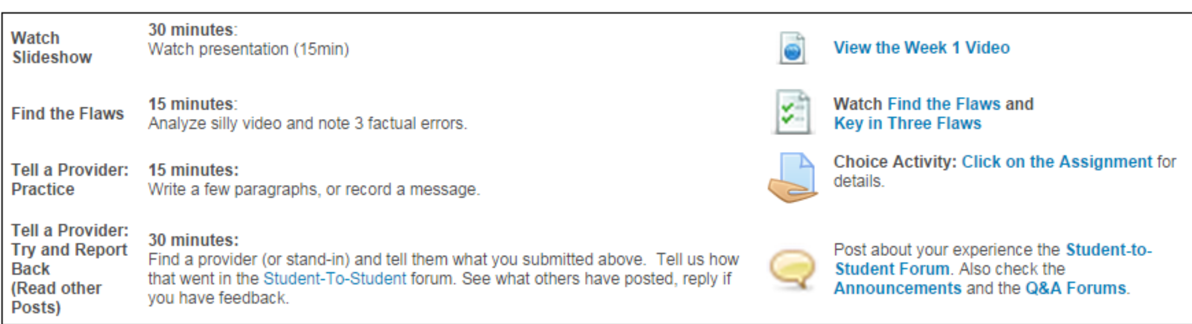


Figure 1: Week Detail

Although there were more activities and resources used, Bram chose to limit all weeks to display only 3-5 links, again to limit student confusion. Activities that were not included in this simplified list but needed to be available were shunted to the bottom of the list, to a "Linked Activities" topic.

All weeks began with a "Work for Week #" page, the video intro for the week, and then links to other key resources or activities that best characterized the week at a glance. The "Work for Week #" layout was consistently set in the same pattern, with title, learning activities, and a clickable outline in table form showing each activity in sequence with details and time estimates (see below).



Watch Slideshow	**30 minutes**: Watch presentation (15min)	**View the Week 1 Video**
Find the Flaws	**15 minutes**: Analyze silly video and note 3 factual errors.	**Watch Find the Flaws and Key in Three Flaws**
Tell a Provider: Practice	**15 minutes:** Write a few paragraphs, or record a message.	**Choice Activity: Click on the Assignment** for details.
Tell a Provider: Try and Report Back (Read other Posts)	**30 minutes:** Find a provider (or stand-in) and tell them what you submitted above. Tell us how that went in the Student-To-Student forum. See what others have posted, reply if you have feedback.	Post about your experience the **Student-to-Student Forum**. Also check the **Announcements** and the **Q&A Forums**.

For the first three weeks, a clickable narrative description was also offered, but feedback during the second live conference call indicated that this was not useful, so it was dropped.

For the three students who had not taken an online course before, and for those who were not very comfortable with technology at the start, it was particularly important to create predictable patterns and clear guidance. The course relied heavily on Forums, in particular News and Announcements and Student-to-Student (Question and Answer was only used initially, as students got accustomed to the technology), but also introduced Chats, Wikis, File Uploads, and collaborative document editing. Students expressed appreciation for this weekly outline format, because it brought a level of consistency to what sometimes seemed like one new tool after another.

> *Kim: Whenever I'd get stuck I'd go back to the clearly laid out 'Assignments for Week ___', and these would ground me.*

Student-to-Student

An open forum for students to connect with each other.

Add a new discussion topic

Discussion	Started by	Replies	Unread	Last post
Week 5: Consultation Planning	Bram Moreinis	5	0	Bram Moreinis Thu, 21 Aug 2014, 9:21 PM
Week 3: Supporting Relationships	Bram Moreinis	19	0	Bram Moreinis Tue, 5 Aug 2014, 8:22 PM
Week 2: SEH Support Brainstorm	Bram Moreinis	33	0	Christine Mace Fri, 25 Jul 2014, 1:37 PM
Week 1: Tell A Provider	Bram Moreinis	8	0	Joanne Buell Wed, 16 Jul 2014, 11:06 PM
Introductions	Bram Moreinis	8	0	Melissa Passarelli Fri, 11 Jul 2014, 3:24 PM

The Student-to-Student Forum at left shows how most weeks had an assignment which required forum posts and comments. Notifications were set to provide daily digests of postings to each student.

1.1.1. General / Misc
1.1.2. Moodle Wiki

General / Misc

- Student Guide to Moodle (PDF for View or Download)
- Posting and Reading Forums (Youtube)
- Taking Screenshots Quick Sheet (web page with links)
- Editing Your Profile (PDF for View or Download)

Moodle Wiki

- Wiki Tutorial (Web Page)
- Detailed Wiki Guide (PDF)
- Moodle Wikis for Students (Youtube)
- Using Wiki (Documentation)

The course design also featured a block of "Key Resources" (Printable Syllabus, Support Wiki, and key documents and tutorials). The Support Wiki, right, was given initial content, then added to with Q&A Forum posts and replies.

Course Content and Delivery

With a few exceptions, all client-developed materials were in Google Apps formats (text documents and slideshows). Because these documents are shared via reference rather than file attachments, the LMS could point to current versions of files as they were updated. All documents shared with students as readings and resources were pared down and reformatted to limit the reading time required and maintain a coherent framework. Where two procedure lists were found, a hybrid list containing both was developed, for example.

Camtasia, Captivate, and Moodle were all introduced to the client through this project. Slideshows with narration and video camera output (displayed in a corner box when not full-screen) began each week's work to develop an instructor presence. Camtasia was used for this work. Rough cuts were recorded by the SME and fine-tuned by the developer, including re-records as well as joining with externally produced videos and splitting into segments of less than 15 minutes each.

The LMS format facilitated designing course activities to reference and apply video content, facilitating discussion of results on Forums. For an example of this progression, view Appendix 13: Week 1 Activity. Most students were Medication Administration Trainers (MATs) and had experience sharing experiences and professional opinions, which the Forum discussions facilitated. For an example, see Appendix 14: Tooth-Brushing Discussion.

Adobe Captivate was used in the first week of the course to develop tutorials that demonstrated and trained participants to customize Moodle, take screenshots, and post to forums, as described above. Both Captivate and Camtasia multimedia were shared using the developer's website, for the affordances of custom player controls. External video clips, on the other hand, were managed and shared using Google Drive.

To integrate video with application activities, the course design relied on Moodle's affordances, including **Forums** (instructor-initiated Announcements), student-initiated Question and Answer, and Student-to-Student with topics tied to weekly activities, but with students able to initiate new discussions.) **Chats** (during telephone conferences, while watching simulcast videos or conducting discussion), **Questionnaires** (for entrance and exit surveys, checklists, and video analysis), and **Wikis** (for

small- and large-group-produced documents). The Vital Signs Checklist (Appendix 2) and Student Responses (Appendix 16) provide an example of using a Moodle Questionnaire to analyze video clips.

Week 4, "Responding to Disruptive Behavior," was the central motivating topic for this course. Infants and Toddlers who become disruptive are sometimes expelled from early child care programs rather than engaged with proactively, which can have a predictive negative effect on future experiences in school. During this week, course learners were led through a number of transitions from content exposure to deeper applications that mirrored what students encountered in practice.

The week began with a two-part narrated screencast / slideshow. In Part 1, Bram oriented students to the "Re-Frame Wiki" (Appendix 3) as tool for analyzing characterizations of disruptive behavior, and re-stating these as more useful observations. In the second half, Emily discussed the two featured video clips of providers, the first "pre-reframing" (with negative characterizations) and the second, "post-reframing" (changing their language after working with a facilitator).

Students were asked to apply the Re-Frame Wiki to the first "pre-reframing" video, re-stating provider complaints blaming children for disruptive behaviors as neutral statements. They were also permitted to view the second "post-reframing" video to help conceptualize the distinction. Next, students were asked to connect this distinction to their own practice, students next recalled similar statements from providers, and add another Statement / Reframe pair.

Now sensitized to the role of provider interpretation in escalating or redirecting disruptive behavior, students were asked to choose from among two videos of providers responding to a disruptive child, and to add one more Statement / Reframe pair to the wiki. This activity most closely mirrored application of course content to the performance environment.

Finally, taking one further step towards application in practice as Child Care Health Consultants, students were given a case study task (Appendix 4). Presented with a request for assistance from a child care provider with a disruptive child named Calvin, students applied a simplified job aid developed for this course, called Think-Through Process (Appendix 6), to offer initial guidance. Students were offered the choice of working initially or in pairs.

This first pass at a case study was preparation for a much deeper pass in Week 5, where students worked in teams, applied much more detailed readings (Appendix 7 and Appendix 8), and took on a more complex Case, involving a child named Eli (Appendix 9). The transition from Week 4 to Week 5 included a one-week break, during which time Emily could analyze student responses (Appendix 17) to the first case and include her reflections in the introductory video for the following week.

In addition to these reflections, Emily also discussed a Worked Example (Appendix 5) of her own response to the Calvin case, providing a model for the desired response and guiding students through consideration of the focus issues from the previous weeks of the course.

Course Management

Instructor Feedback

Emily provided detailed responses to all student forum posts. For a sense of the quality of these exchanges, view Appendix 15: Instructor Feedback to Week 3. Beyond forum replies, instructor feedback was provided during each of the three conference calls, and as described above, in the intro video to Week 5 which included video response to student case studies. There were also email exchanges throughout the course, and occasional telephone calls, in response to Bram's weekly status reports when students were identified who had stopped participating.

Emily's responses were supportive, facilitative and extensive rather than evaluative. She strove to identify each participant's strengths and experiences as reflected in their forum posts and submitted work, and to provide examples of her own experience to guide students to make further connections. Students concurred that Emily's forum responses, as well as the materials she developed from her professional experience, were the most valuable part of the experience:

> Kim: *Emily, your case examples were brilliant and your modeling of appropriate responses was the best part of the course. … The interactive pieces were the biggest challenge (no surprise), but I was very impressed with how you both pulled these together, and made some sense of everyone's responses.*

A key premise of the course was the value of establishing a Community of Inquiry where students learned together, from each other's responses, and one of Emily's goals was to refer students to each other's posts in her replies. Here is one example:

> *Emily: [This exchange] was a good example of jigsaw: now that Lana brought out hearing loss (her personal experience) others will be able to remember. This enabled each of us to share and INTERNALIZE each other's points of view and knowledge base. This is a good argument for the CCR&R email group. Strength in numbers and in diversity.*

Technical Support

Because this was a first time taking an online course for many students, and because some expressed a low level of comfort with technology in their entrance surveys, high-quality, responsive technical support was important for this course. The first week (known as "Week 0") was dedicated to preparing students to use Moodle, but also provided training in how to take screen shots in multiple operating systems and post these to the Q&A Forum, to facilitate solving problems.

Technical support was provided through many channels: the Q&A Forum, individual email, telephone, conference calls, narrated screencasts and in two cases, interactive tutorials. The proposed workflow was for students to post questions to the Q&A forum first. Bram would answer them there, and follow up with course announcements (if a difficulty was discovered that all students needed to be apprised of) linking, if needed, to posts to the Tech Support Wiki (which would provide detailed instructions for solving problems).

In practice, some issues needed to be resolved through remote screen-sharing and telephones, either because of the level of computer fluency of the student, or because of issues of home computer systems unrelated to the course technologies.

When Google changed its policy for sharing videos stored on Drive during a week of video analysis (requiring Google Accounts to access what had previously been public) the problem was quickly remedied, thanks to students feeling comfortable asking for help. In one instance, a Wiki had not been configured properly, and students chose to submit their comments via Forum rather than alert Bram, assuming that it was their own error rather than his.

This issue came out in a subsequent conference call, and highlighted the importance of having an open, responsive, blame-free environment for the surfacing of issues. One of the limitations of a six-week course is that there was little time to relax into a new activity tool (Forum, Chat, Wiki) before a new one would be introduced. No matter how much support was available, the pace of introduction could be daunting:

> Christine: *The format for some of us who are computer literate but not that advanced was confusing*

However, the student who was clearly the most technologically challenged of the cohort was not shy about sharing whatever difficulties she experienced and asking for help, and her participation did not waver. Her forum postings showed deep engagement and benefit from each of the activities, and she expressed her appreciation for the depth of tech support provided:

> *Dear Bram:*
>
> *I just wanted to tell you thank you for all your patience and understanding with me and my computer skills. I have started to feel comfortable with the skills you have taught me. I have learned new computer skills from you and this course.*
>
> *I hope when you roll this course out you will still have the instruction portion where you can see exactly what the student is doing right or wrong and provide the help immediately. This type of help was great for students like me who are uncomfortable and even frightened by trying to learn new computer skills and course material at the same time. Without your help and calm demeanor I would have dropped out of this course after the second week.*
>
> *I am glad I struck with it not only for the computer skills but also for new information that I was able to put into practice immediately. The red flags of SEH were a god send. I have used those handouts at three centers already. It is a good visual for the director and the teacher's to see what is working in their classrooms and what needs to be changed. It's a tool which I am going to suggest that the directors use the information from this course for new staff at their orientation.*
>
> *Emily's videos should be available for directors to present at upcoming in services. They are short in length, to the point and understandable at any level of education. The SEH course also meets one of the OCFS categories for growth and development and would count for hours or CEU's for required training. I believe it would also be eligible for EIP monies. This would be a win-win for the director not only does it count for in-service hours the provider would also get paid back from EIP.*
>
> *Thank you again it was a pleasure to meet and work with you. Hopefully this will not be the last time I take an online course with both you and Emily.*
>
> *Debbie*

Student Reviews of the Course

> *Joanne: "Having each other as an audience helped raise the level of professionalism. Challenge: Providers will respond with emotion, CCHCs need to hold back and come from a more professional place."*

Evaluation Goals

Initially, this project had been proposed as a narrated slideshow with quiz questions, designed for information transfer. Developing an online course would not have been possible with the funds allocated. The current environment for funding projects for early child care education in New York State is limited, and it will be a challenge to raise money for instructors to teach further iterations of this time-intensive course, let alone develop new courses along this model.

In addition, a significant effort would need to be made to certify the course so that participants earned professional development credits for licensure. To support this certification, as well as to prove the concept as part of additional funding requests, an evaluation of the model and its implementation (to the degree these can be separated) is needed.

Bram had proposed that the online course would accomplish key goals which the previously envisioned informational videos and tutorials could not:

1. Transfer knowledge and attitudes through engagement, communication, and collaboration.
2. Develop a Community of Inquiry, preparing to support an online Community of Practice.

Docs for Tots has an extensive curriculum prepared for development. This course is positioned to be the first in a series. Two key evaluation question for Docs for Tots (and for its potential funders) are:

1. Did the course results demonstrate the value of the design model clearly enough to justify applying for professional credit certification and seeking funding for additional sections?
2. As a follow-up, would the strategies behind the learning activities designed for this course be applicable to the other curriculum topics, or would video tutorials suffice?

To make this case, student forum posts and evaluation surveys should convey understanding of presented material, but also a desire to apply and advocate for Docs for Tots' program in their practice. Student exchanges should evidence peer learning, and exit surveys should attribute value to the multimedia, activity designs, and learning community. This review will seek evidence of:

1. Knowledge transfer (course content domain)
2. Attitude transfer (change of practice advocacy)
3. Skill transfer (related to online learning, for students new to the medium)

In addition, this review will share and summarize student report of appreciation for peer learning, instructor presence, course materials, and course activity designs, particularly as the latter relate to deepening engagement with materials and fostering effective collaboration to support an evolving Community of Practice.

Knowledge Transfer

The initial slideshows provided by Docs for Tots were rich in content, particularly in scientific research. Bram's contention was that passive consumption of this information would not lead to transfer, and designed for breaking that content into smaller chunks, and addressing each chunk with a sequence of applications that increasingly mirrored the performance environment.

In the progression from Emily's presentation to "Find the Flaws" to "Tell a Provider", students needed to understand the material well enough to recognize errors when presented informally (by Liz, in a video), and then to re-present it to a provider who lacked their medical training.

In their exit surveys, Christine and Kristin expressed value for the depth of content shared in Emily's videos. Lana commented on how the activities required deeper retention than a first viewing:

> *Lana: After watching Emily's video and then the "find the flaws" video, it was very clear what the flaws were! I started to practice the dialogue I would use to tell a provider and then decided "I need to view Emily's video a second time".*

Debbie and others were particularly grateful for the printed materials (job aids and primers) we developed for this course:

> *Debbie: I take the handouts for SEH with me on center visits [to help me] start a non-threatening conversation with either the director or teacher whomever I am speaking with.*

One of the highlights of the course was Debbie's experience with the "Tell a Provider" activity, to which Emily had composed her lengthy reply cited earlier. Here are excerpts from Debbie's forum post:

> *Debbie: I had lunch with an infant-toddler head teacher and we discussed what I had learned in the first week of class. While I gave an overview of what I learned I found she was not interested. Then I realized I was talking very clinically. Giving her the 700-per-second neuron development, adult-child interaction, fact after fact of information did not interest her.*
>
> *When we started to talk about her room, however, we incorporated information that would be useful to her. I gave her a copy of the vital Signs Supporting Relationship Handout. She then could see why I was telling her about neuron development and the importance of face to face interaction with infants and toddlers. Pruning and strengthening brain development were also discussed.*
>
> *We were able to look at the positive behavior already being done, while looking at some of the Red Flags that were also being done. She told me it was the first time someone had approached her with a suggestion and handouts that were useful and not punitive. As with myself, Janelle did not realize that at this age children could be under a toxic stress effect, and that we could affect a child for his or her life in such an adverse way.*

What both instructors found particularly significant here, and what supports the course design, was that this student was able to make the transfer from presented, scientific material to application in practice at the time the material was presented, during the course. Also, she was able to validate its applicability in her consulting role. Other students could see the potential value, even if they were on summer vacation that week and not able to apply the task to the performance environment:

> *Kristin: I have not had the chance to "Tell a Provider" yet. However, I know that when I do, I know that I have more information and knowledge to expand on the topic and be able to answer their questions.*

In response to the exit survey question, "Do you feel able to positively affect Social Emotional Health in child care settings as a result of this course?" students wrote:

> *Joanne: I will be more aware of infant/toddler red flags and more comfortable approaching providers.*
>
> *Debbie: I have more knowledge of what Social Emotional Health is and how infant/toddler teachers and staff don't interact properly with children.*
>
> *Kristin: I feel that I will be able to incorporate what I have learned here into my site visits as well as interactions with providers. I also have learned to not just jump in to the infant/toddler specialist…that there are valid suggestions and observations that I can make to providers, and then work up the ladder of referrals.*
>
> *Christine: Yes.*
>
> *Lana: Having little experience with observations in childcare settings I learned many new ideas that I will be interested in using with providers to create an emotionally safe environment that will enhance child development.*
>
> *Kim: Not particularly, but my SED knowledgebase is perhaps more extensive than most.*

Attitude Transfer

Docs for Tots is as much an advocacy organization as an educational one, and this course begins with strong arguments for improving awareness of Social Emotional Development (SED). One position is that the Child Care Health Consultant (CCHC)'s role should be interpreted to include mental as well as physical health, because of the impact of failure to support SED in infant/toddler care, whether at home or in institutional settings.

Throughout student postings, the recognition of this need is assumed. As stated above, this first cohort was made up of CCHCs who were already converted to that cause, hence their interest in getting the background to more effectively embody the social emotional health consulting aspects of their role, and to advocate for that re-positioning in their communities of practice and field settings. As Kim, the Health Consultant for NYC's Early Care and Education Division, wrote:

> *Kim: I am very thankful that you are both fighting that good fight, and it speaks very highly of your commitment, and your understanding of what's really important, that you chose SEH as the starting point. I am honored to have been a part of this.*

Once the course is approved for medical education credits and can reach a broader spectrum of CCHCs, supporting attitude changes regarding the role of the CCHC will be a more necessary outcome. Comparison of entrance and exit surveys will be more likely to reflect such changes. For this pilot round, we preached to the choir.

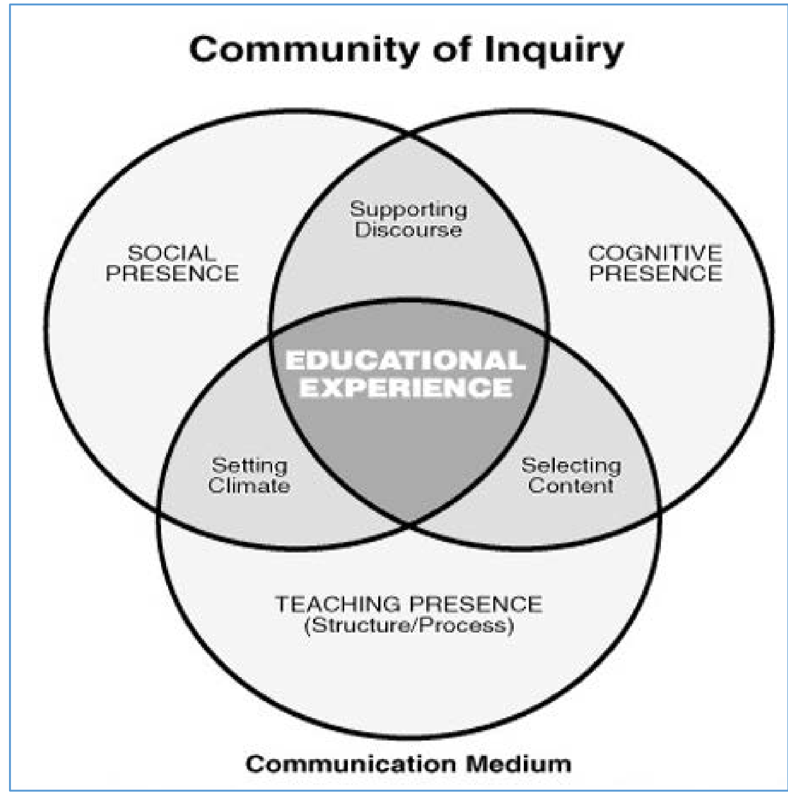
Skills Transfer

Although this course addressed the cognitive domain (both in content and in the application of methods to consulting) and the affective (developing greater investment in changing practice and advocating for SED), there was no work in skill development, except in regard to taking online courses and using computers. For the three who had not taken online courses before, this transfer was successful.

> *Debbie: The assistance from Bram was professional and his knowledge of computers was the best. He spoke softly to me whenever I had a problem. He answered my questions promptly. He never made me feel uncomfortable or stupid.*
>
> *Kristin: I enjoyed how the course moved from simple technology to more involved. I really enjoyed learning about Moodle and how to work within it. … Bram was most helpful to all that were having difficulties.*
>
> *Kim: I think the design is a good one and will work even better next time, particularly if with the same people; i.e. I consider myself reasonably tech savvy but found myself struggling with the process. The learning curve was steeper than I had expected. But now that I have a reasonably good grasp of it, I feel badly that I will no longer be using the interactive skills I've learned (or at least have started to learn).*

Subsequent courses using this format, designed as follow-ups for cohorts who have taken this one, will not require the time and attention to training materials and the depth of technical assistance required.

Peer Learning



Another key premise of the course design was the Community of Inquiry model (diagram at left: see *Elements of an Educational Experience (Garrison, Anderson & Archer, 2001)*, which values social learning, arising from a climate of shared exploration and the context of discussions that both facilitate peer mentoring and knowledge exchange and reveal gaps and needs that can guide process and presentation.

Students cited the benefits of peer learning in forum discussions:

Lana: *I was reminded of the time a class participant caught me in error and how careful I need to be.....often there are class participants with more knowledge on topics than myself!*

> Debbie: *I like the interaction with the other participants via conference calls and the internet. The information the other participants added a special additive to the course. Their knowledge and experience was invaluable. … Now that I have met so many other CCHCs from this course I will keep everyone's name and email in the event I need help in their areas of expertise.*

Forum discussions also revealed knowledge gaps, which for one student (the city appointee in charge of CCHC education) suggested that a more basic, content-centered course should precede one weighted further towards peer learning and collaboration:

> *Kim: I was taken aback by some of the comments on the scenarios, and found myself thinking that CCHC's need a lot more training on SEH issues, particularly a better understanding of the concept of developmental appropriateness.*
>
> *It made me wish there were more didactic parts to this training. There's a good case for a better grounding in Social Emotional Development before we can really tackle Social Emotional Health. Without a shared understanding, without a shared knowledge base, the natural risks of interactivity--the extent to which it encourages the notion that all points of view are equally valid--become more pronounced.*

Kim's proposal merits consideration. However, not all students might engage as well with a purely didactic course. The collaborative activities, particularly towards the end when students developed consultation plans as a group, generated enthusiasm and very rich discussion:

> Lana: *I was blessed when working with Joanne. She pulled our week 5 project together so well and has great skills. It was a very good opportunity to get to know other CCHCs and learn from them.*
>
> Kristin: *I also enjoyed collaborating with other HCC's and brainstorming over our last project. It was an enjoyable learning experience.*

Course Activity Designs

An evaluation of activity designs should reflect accuracy in gauging the time required, effective progression from content presentation (the default offering originally sought by Docs for Tots) to active engagement and application, and use of online learning tools to support rather than complicate learning. Because this was the first iteration of the course, universally appropriate pacing, depth, and technology comfort would not be an expected outcome. However, with one or two exceptions, the pace of the course, and the expectation of a two hour per week workload, was achieved:

> *Lana: I liked the progression of the coursework.*
>
> *Joanne: The estimated 2 hours/week time commitment was fairly accurate.*
>
> *Joanne: I liked the pace and the interaction with others.*

One student had higher expectations for the quality of his participation, and for him, the two hour estimate was low. However, even though he limited himself to two hours, he provided much more than his share of expertise and deep participation. He wrote:

> *Kim: Two hours a week was not sufficient. That was pretty much the amount of time I put into it, and it wasn't near enough. 4-6 would be more appropriate for this course, particularly the*

interactive pieces. If I'd had more time I would have been a lot more interactive. I had pages of notes for one of the assignments that never got used because we had moved on."

Other students also expressed a wish that the course extended over a longer period time, perhaps with two-week rather than one-week work cycles. There is no reason not to try this on the next iteration:

Joanne: I felt it would have helped me if the assignment was given and completed so we could share more of our ideas when we "met" together. Sometimes I really wasn't sure what the assignment was looking for and didn't contribute as much as I could have.

Kim: I would have liked more weeks at Step 2 of the design. Step 1 had the right amount of time, and Step 3 was fine (but for me it suffered from the rapid speed of Step 2). …

Regarding the design and sequence of assignments, however, all students approved:

Kim: The sections that were non-interactive were very straightforward, and the flow of the assignments was wonderful. … I certainly participated enough to know that this model has many strengths. And it should be pursued. I would be willing to do it again. You should know that this course kept me very engaged when I was able to fully participate, and that's a high compliment, because this was one of the most challenging summers I've ever had.

Joanne: Overall, I enjoyed the format, course materials, topic and other participant perspectives.

Debbie: I liked the design of this course. For me it was outlined clearly what was expected of us to complete this course. The videos were understandable and were thought provoking. The assignments were through and not time consuming. This was great due to my work schedule and life schedule.

Kristin: I also liked the mixture of the course presentation styles - videos, reading and collaboration. This kept the learning environment fresh and not just signing on to read and then write the assignments.

Interest in another Online Course

In response to "Would you consider taking another CCHC online course? If so, what topics would you be interested in covering?" one student was undecided, but the others were strongly positive:

Joanne: Yes, general consultation, special medical needs support and consultation, medical myth busting (lice, bedbugs, other conditions.

Debbie: Yes, I would, but only if Bram is there to help me through the computer work. I am still nowhere near being comfortable with my computer skills.

Christine: I hope to see more courses for HCC like this one in the future. There are not many out there for us! Thanks for putting this together.

Kristin: Yes. I think common childhood illnesses as well as disease processes we all run in to.

Kim: Yes. Part II of SHE: SED. More! … I think the focus at the end on continuing in some fashion is a good idea, and I look forward to helping make that happen. I just wish you could convince OCFS (or I convince NYC DOHMH or ACS) to put some money into it!

Appendix 1: SED Pledge

SED Pledge

I believe that:

- babies need close caring relationships in child care

I pledge to work with my child care program to:

- Establish and support primary caregivers
- Create policies that maintain primary care-giving relationships for longer periods
- Reduce the number of transitions during infancy
- Reach toward the goal: One caregiver from enrollment until preschool!

Strategies I will use include:

1. **Resources:** Share general resources and information on social emotional development with providers and centers.
    1. Forward Internet Resources (e.g. Youtube videos)
    2. Share printed resources, with parents as well as providers, e.g. "Vital Signs".
2. **Family Connections**: gain insight into parent knowledge and understanding.
    1. Create a "Parent Resource" bulletin board.
    2. Create a paper survey for parents.
    3. Create a Parent Newsletter, or contribute to one that exists.
    4. Target parents whose child is lagging in SED for resource sharing, possible autism exploration.
3. **Referrals:** Make strong hand-offs for emerging social emotional issues and behavior changes to community services and experts we know are effective.
    1. Infant/Toddler Specialists
    2. Child Care Resource and Referral Agencies
    3. Community Advocacy Center
    4. Regional Early Childhood Direction Center
    5. Early Intervention Program
4. **On-Site Coaching:**
    1. Look more for positive behaviors than red flags, mention the positives first.
    2. Let discussion arise about positives if possible, rather than cut off dialog with negatives.
    3. Model positive interactions.
    4. Bring glaring negatives to the director's attention.

5. **Classroom Management**:
    1. Emphasize importance of positive first child/provider and child/teacher interactions to build relationships.
    2. Help providers and centers understand and promote social emotional health through activity programming.
    3. Assist child care providers and centers in managing behavioral issues at the classroom level.
6. **Packaged Trainings:** Promote trainings and conferences that address social-emotional health to providers: in-services, online courses, and seminars.
    1. PCAN (Preventing Child Abuse and Neglect) designed by Zero to Three.
    2. CSEFEL (Center on the Social and Emotional Foundations for Early Learning)
7. **Phone consults:** before or in place of a site visit.
    1. Preventing expulsion.
    2. Prepping for a parent consult.
8. **Stress Reduction:** Help providers recognize work-related stress they are experiencing,
    1. Allow the provider to voice frustration.
    2. Assist in re-framing the situation in ways that allow for solutions.
    3. Help find strategies to address the situation.

Appendix 2: Vital Signs: Supporting Relationships

VITAL SIGNS: Supporting Relationships

An environmental scan for evidence of provider behaviors that promote Social-Emotional Development.

Infants	
Positive provider behaviors	**Red Flags**
General: • Provider satisfied, proud, confident • Infants smiling, cooing, babbling, seeking adult attention • Mobile infants exploring • The classroom is peaceful and/or happy • The classroom is infant oriented	• Many infants crying • Infants sleeping in swings, vibrating seats • Provider use of "no" with infants • The classroom seems chaotic • The classroom is adult oriented
Response to need: • Needs acknowledged • Picked up/soothed when crying • Provider calm, confident	• Frustrated/stressed provider
Feeding: • Held • Looked at • Individual schedules • Food exploration encouraged or at least tolerated (as culturally appropriate)	• All infants on same schedule • Food exploration restricted
Language: • Serve & Return • Descriptive language • Language extension	• Babies in containers • Quiet babies ignored
Routine care: • Individual interaction with diaper changing, hand-washing etc.	• Changed at set times on a schedule •
Playtime: • Babies at liberty on floor • Provider on floor with infants	• Infants in containers- swings, bouncy seats, etc.

Toddlers	
Positive provider behaviors	**Red Flags**
General: ● Provider enjoying the toddlers ● The room is happy and joyful ● Toddlers are active and playing ● Supervision is gentle and constant ● Parents are welcome & there is a mechanism for communication	● Provider use of "no" with toddlers ● The classroom seems chaotic ● The classroom is adult oriented ● Many rules ● No routines
Response to conflict: ● Providers identify emotions ● Responsive to individual need ● Encourage problem solving ● Provider stays calm	● Numerous incident reports ● Provider stressed ● Use of time out (especially if excessive)
Snack & mealtimes: ● Family style meals ● Providers eat with children ● Adults and toddlers enjoy meals	● Children made to wait to eat ● No food exploration is permitted
Playtime: ● All items within reach are open for play ● Variety of activity areas including space to be quiet or alone ● Art is exploration	● Expectation to produce recognizable art products ● Activity areas are crowded ● Movement as a large group between activities ● Little to no time outdoors
Provider-led activities: ● Use of rhyming, singing ● Group activities are brief ● Children permitted to leave group ● Alternative activity provided	● Circle time long ● Developmentally inappropriate activities
Language & literacy: ● Opportunities to sing, rhyme, finger plays ● Access to books all day ● Providers extend toddler language ● 2-way conversations	● Access to books is restricted
Routine care: ● Self-help skills encouraged ● Potty training/toilet learning is managed with comfort ● Hand-washing is routine	● Strict potty training ● Shaming for accidents

Appendix 3: Reframe Wiki

PROBLEM STATEMENT	RE-FRAMED STATEMENT
Example 1. He whines from the moment he gets here until the time he gets on the bus to go home.	He must really miss his family.
Example 2. She is clingy not only with her mother but with other adults as well.	She might be slow to warm up in new settings or in the presence of other children and adults.
Example 3. I have to watch him like a hawk or he'll run down the hall or go out the gate.	He may not understand my expectations about staying with the group. He is very active. He may need to run off some energy in the gym before being able to listen to instructions.
Example 4. She constantly knocks over other children's constructions or destroys other children's art work.	She may want to join other children's play, and she may not know how to ask. She may be frustrated because she does not know how to play with the materials or complete her art project. She may not feel welcome in the group
5.He won't listen may turn away	He should be checked for hearing and or ear problems?
6.When he got upset, he threw chairs, hit the teacher, kicked.	Something upset him, what happened just prior to the upset? What frustration is he trying to communicate?
7.Michael 3.5 Michael pulls his chair to the spot he chooses at the table and proceeds to grab play food and throw it.	Michael may have a favorite table spot that he likes, he may actually be hungry and he needs to have instructions from the adult on what to do. He responds well to direct adult instruction re "saying sorry".
8.West was expelled from two daycare centers for biting. I would like to enroll him in my FDC but I am	You have a very rewarding opportunity to help this child overcome this negative response he

afraid that his behavior will upset other parents and I might lose those children.	has been practicing when he becomes stressed. Being in a smaller group will permit you to observe those situations which cause frustration for West. West may feel threatened in a large room with many children amd may be able to conquer biting with your help.
9.Michael is very whiny today	Let's communicate with his parent's.We should check with his parents to see if he is feeling alright? did he sleep o. k. ? Did anything happen at home?
10. Michael seems to be moving from space to space never staying in one area to long	Does this space need to be evaluated or rearranged? Maybe its to small or crowded for Michael

Appendix 4: Case Study ("Calvin")

Case Example: Calvin

PROBLEM CASE

This is a request for Technical Assistance from a Provider you have seen previously.

Provider requests you evaluate an almost 3 year old whose behavior was challenging to the point that the program was considering expulsion. Per their report this would be his third expulsion from a child care program and they were regretting having ever enrolled him. Provider understand that a CCHC does not evaluate the child, but can make recommendations for program changes to support him in managing his behavior.

You have met the child on your previous visit, a very energetic little boy we'll call Calvin with limited impulse control, fearful classmates, and a very controlling teacher who ran the rest of the classroom with a firm, but loving hand. But seemed to have just one strategy for this little boy which was time-out and which he appeared to dread. The provider who attends classes with Calvin, who is requesting your consult, appeared to appreciate Calvin's impish behavior and infectious smile, but was unsure how to manage his outbursts.

In your previous visit when you met Calvin, he was already in time-out which consisted of a wooden stool in one corner of the room. The teachers had excellent visibility to the corner and while Calvin was there, they repeatedly warned him to sit still and think about why he was in time-out. The most prominent issue you noted was that the room was set up in small square stations for a variety of activities. Each station appeared crowded if there were more than two children and a teacher present.

When Calvin was released from time-out, the lead teacher immediately began with frequent verbal reminders to Calvin to not run, don't push or you'll go back in time out, etc. As anticipated, Calvin was soon returned to time-out after pushing a child in the block area over possession of a dinosaur.

What modifications can the Provider suggest to Calvin's teacher to avoid expulsion from the program?

Last modified: Sunday, 29 June 2014, 5:18 PM

Appendix 5: Worked Example: Response to Calvin's Case

FIRST SOLUTION STEP

What is the problem?

SECOND SOLUTION STEP

What kind of consult is this?

THIRD SOLUTION STEP

What aspect of consultation is most relevant / provides the most leverage?

Emily's Solution

Good Solutions

The following are suggested best answers for this case:

1. Adjust the room arrangement to allow for more open space and less confining activity areas. These are fine for the children with more self-control, but for a child with high energy and low impulse control, it is just too stimulating.
2. Replace the timeout area with one that promotes self-regulation if the stimulation level gets too high. Suggest Teacher or Provider provide guided imagery to help Calvin imagine a place where he feels relaxed and at peace, like the Carribean.
3. Teacher and provider try to embrace Calvin's energetic side and to structure more activities that would help him to burn off some of that energy. And also that they model and practice situations of self-control especially if they are feeling a little over-stimulated themselves.

What Actually Happened

CCHC (Emily) received a phone call two weeks later asking if she'd like to come see the 'new' Calvin. The timeout corner has been transformed to a beach complete with a fake palm tree, brown blankets to cuddle up on and a child friendly CD player with calypso music.

The provider proudly shows how she would redirect a child or even herself to the beach if the stimulation level was getting too high. She put an ocean CD on, lay back in the blankets, closed her eyes, and took some deep breaths. She was soon joined by Calvin who mimicked her behavior and also visibly relaxed. She explained that if a child was getting a little wild, she would suggest they 'go to the beach'. It wasn't a punishment anymore, but an opportunity to regroup and regain control.

The lead teacher also expressed how surprised she was that the beach idea worked and how well it worked.

Appendix 6: The Think-Through Process

SOLUTION STEPS

1. What is the problem?
2. What kind of consult is this?
3. What aspect of consultation is most relevant / provides the most leverage?

ROLES TO ASSUME

Which of the following roles could you assume that would be helpful?

1. Collaborative consultant
2. Policy developer
3. Advocate
4. Health educator
5. Referral and resource provider

CONTEXTS (what stage are you at with this provider?) See CCHC Handbook, pp. 23-44

1. **Initial:** Introducing yourself and your services.
2. **Assessment:** Determining Provider Needs
3. **Interim:** Before coming up with a change plan / process.
4. Program Improvement Plan
5. Technical Assistance
6. Teaching/Training
7. Referral
8. Discharge or Transition
9. Special Visits:

a. Measles Suspect

b. Failure to Progress

ACTIONS TO SUGGEST

Which of the following actions could be helpful? (there are others … this is just a start!)

1. Build relationship between Provider and Child (provider education)
2. Support Continuity of Care (program design)
3. Support Provider Mental Health (stress management for relationship readiness)
4. Gauge Mismatches between child and provider to establish care continuity.
5. Support a Developmentally Appropriate Program Structure and match with temperament.
6. Assist with Pediatrician / Early Intervention Referrals for children with challenging behaviors.

Make a Strong Referrals (warm hand-offs / assisted linkages between providers and doctors, infant/toddler specialists, etc.)

Appendix 7: Mental Health in the Child Care Setting

Mental Health in the Child Care Setting
version 3, revised 2/12/2013

SUPPORTING CHILDREN WITH SOCIAL AND EMOTIONAL DIFFICULTIES

It is appropriate to seek early childhood mental health consultation and support anytime a child's behavior is causing prolonged distress for the child, parents/guardians, and/or the caregiver/teacher. Early childhood 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/guardians, and caregivers/teachers (e.g., infants not sleeping well, biting, toddlers having difficulties with toilet learning, and preschoolers being very active). The following section details how to assess children's behavior and some common responses to difficult behavior that might assist the child care staff in taking steps to promote mental health before having to contact a specially-trained early childhood mental health consultant.

How to Identify Children with Social and Emotional Difficulties

Important Risk Factors: Staff should obtain as much information as possible from the parents/guardians and primary care provider in order to be alert about any special needs. For example, the caregiver/teacher should have relevant information about the child's prenatal and birth history, medical conditions, development, temperament, likes and dislikes, family relationships, and previous child care experiences. Studies have shown that children with particular risk factors are significantly more likely to experience mental health problems (Shore, 1997). Although many children who experience these risk factors remain mentally healthy, caregivers/teachers should observe these children more closely for signs of distress and provide them with extra support. According to Shore (1997), important risk factors include:

Family stress	Military deployment of a parent/guardian
Maternal depression or other mental illness	Death or loss of a family member
Poverty	Neglect or abuse
Substance abuse	Special medical/developmental needs
Homelessness	Physical or mental disability
Family violence	Chronic medical conditions

Behavioral "Red Flags"

Children communicate their feelings and needs through words and behavior. While the caregiver's/teacher's main focus should be observing and supporting children's pro-social, successful behaviors, she/he should also be attentive to behavioral red flags that may indicate social and emotional difficulties. Experienced caregivers/teachers report that they have a sixth sense for identifying children

with social and emotional difficulties because these children provoke uncomfortable feelings in others. Their behavior is often characterized as:

- Emotionally extreme (extreme anger, sadness, or giddiness)
- 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, and/or out-of-control
- Displaying little or no interest or ability to play with peers
- Suddenly changing emotions (e.g., from outgoing to withdrawn)
- Excessively fearful of certain, people or objects
- Regressive in behaviors where child had previously shown mastery

Caregivers/teachers should also consider the following as red flags for mental health problems:

- Disclosure of harm by an adult
- Play themes that demonstrate inappropriate material for age and ability of the child

Based on his/her initial assessment the caregiver/teacher must determine whether a child's behavior is part of normal development or a red flag for social and emotional difficulties. Caregivers/teachers should monitor the children's development, share observations with parents/guardians, and provide resource information as needed for screenings, evaluations and early intervention and treatment.

CFOC 2.1.1.4 Monitoring Children's Development/Obtaining Consent for Screening

Consideration should be given to utilizing parent/guardian-completed screening tools, such as the Ages and Stages Questionnaire. These may help with an assessment of whether a behavior is developmentally-appropriate for a given child.

Confirming Behavioral Concerns

While all children experience difficult emotional and social episodes, these become mental health problems when the difficulties persist over a period of time and in different settings, often despite negative consequences. 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 attempts to teach acceptable behavior, the caregiver/teacher should take further steps. To get objective information about problem behavior, the caregiver/teacher should:

- Observe and document the child's behavior over time and in a range of different relationships, environments, and activities
- Have a colleague or supervisor observe the child to provide a different perspective and/or independent confirmation of the problem behavior
- Express his/her concerns to the child's parents/guardians and work together with them to understand the behavior and develop strategies to better meet the child's needs

- With the parents'/guardians' consent, request that an early childhood mental health consultant observe and assess the child and provide consultation on strategies to support positive behavior and/or referral for intervention

Meeting the needs of children with social and emotional difficulties can be challenging. It is critical for caregivers/teachers to know when and how to seek additional information and help from the family, colleagues, supervisors, and early childhood mental health specialists. Caregivers/teachers can keep journals of their observations of children and their own responses to help identify the support they might need to help children with social and emotional difficulties.

How to Respond to Children's Behavior

Interpret the Meaning of the Behavior Caregivers/teachers and parents/guardians must use their understanding of the individual child, his/her particular development, temperament, and life experiences, to interpret the meaning of the child's behavior and to respond to the child's needs. Remember, a child's behavior is often prompted by a combination of causes. The art of responding appropriately is in taking many factors into consideration. In trying to interpret the causes of a troubling behavior, caregivers/teachers should consider the following explanations and should keep in mind that there may be multiple causes of behavior. The table on the following page lists how to tell if a child's behavior is caused by any of these explanations and, if so, how to respond.

Developmental Skills: Young children are learning everything for the very first time and need many opportunities to have things explained and to practice new skills. Each developmental stage has predictable behavior that accompanies it. The behavior is the child's way of practicing the important tasks of that stage. Some of these behaviors can be frustrating for caregivers/teachers, but they are a normal part of child development.

Individual Traits: Each child is born with unique physical characteristics and temperament. These characteristics influence how the child experiences and responds to his/her environment.

Home Environment: Each child carries experiences and expectations from home into the child care environment. The home environment, including the language, culture, food preferences, and rules for behavior, influences the child's behavior and response to child care.

Child Care Environment: The child's entire experience in the child care program— relationships with children and adults, the caregiver's/teacher's style of interacting with children, the physical environment, and activities—shape the child's behavior. When children act out in response to features of the child care environment, their behavior will improve when the caregiver/teacher changes his/her own behavior, activities, or the environment.

Unmet Emotional Needs: All children have fundamental emotional needs for safety, consistency, trusting relationships, and feeling competent in the world. When these needs are not adequately met, the child lacks something critical for his/her emotional development. Until the emotional need is satisfied, the child is driven by a hunger for it. Troubling behaviors can be a child's attempt to get what she/he needs. Even though it might not be successful, the behavior won't go away until the underlying emotional need is understood and satisfied.

Table 1: Explanations of Child Behavior

Explanation of Behavior	How to tell if behavior is caused by this explanation	How to respond if behavior is caused by this explanation
Developmental Skills	- The behavior is described in child development books. - Other children at the same stage are observed to behave this way. - The child is in a new situation or facing a new task or problem.	- Remember that this is normal for children. Tolerate the behavior—it will end as the developmental stage passes. - Channel the behavior, allowing it in certain places at certain times. - Model appropriate behavior. - Explain why not to do the behavior and teach the child a “replacement behavior.” - Give encouragement for small successes and be patient with failures. - Stop the behavior when it is disruptive or dangerous. Be firm and patient. Use words and actions that don't make the child feel bad about him/herself.
Individual Traits	- The behavior is not explained by developmental stage alone. - Upon observation, this child's temperament style is a consistent quality in his/her behavior. - The child's family confirms this quality has been consistent since infancy. - Research indicates that this type of behavior is characteristic of certain temperament types.	- Accept the child's unique qualities. Try to see the child's positive traits. - Adapt expectations and interactions to fit the child's abilities and style. - When possible, offer acceptable options for activities that are consistent with the child's way of expressing him/herself and responding to the world. - Change the way the adult interacts with the child to obtain a different outcome.
Home Environment	- There are significant differences between the routines and cultures of home and child care. - The child's behavior has changed suddenly, corresponding with changes or difficulties that the child is experiencing at home.	- Get more information about the home environment/culture from parents/guardians. - When possible, adapt expectations in child care to accommodate the child's family and culture. - Provide support for the child. Make child care a safe oasis for children who may be experiencing difficulties at home.

<table>
<tr><td></td><td></td><td>- If there is reasonable suspicion of child neglect or abuse at home, child care caregivers/teachers in NY are legally obligated to report this suspicion to Child Protective Services.</td></tr>
<tr><th>Explanation of Behavior</th><th>How to tell if behavior is caused by this explanation</th><th>How to respond if behavior is caused by this explanation</th></tr>
<tr><td>Child Care Environment</td><td>- The behavior is not simply explained by a developmental stage or individual traits.
- Many children in the group have the same behavior.
- The group is responding to a specific condition or activity.
- When the condition in the environment changes, the behavior changes.
- The behavior is not present when a different caregiver is in charge.</td><td>- Change the environment.
- Make sure the child care program is developmentally appropriate and that children experience sufficient protection, attention, stimulation, order, and calm.</td></tr>
<tr><td>Unmet Emotional Needs</td><td>When ALL of the following are present:
- The behavior is inappropriate—the child is not acting his/her age.
- The child has a limited way of responding and uses the same behavior repeatedly.
- The behavior has a driven, intense quality—the child has to do it, despite repeated, negative consequences.
- The behavior is persistent, even when channeled or stopped it keeps recurring.
- The usual ways of helping children with this behavior do not seem to help this child.</td><td>- Try to figure out what need the child may be trying to communicate.
- Remember that the behavior doesn't usually look like a need. Ask for help from colleagues, supervisors, and mental health consultants in analyzing the function of the behavior.
- Respond actively to the child through deeds, not only words; through giving, not withholding; through support, not punishment.
- Stop the behavior when the child is hurting him/herself or others. Use quiet firmness and patience.
- Get additional support for yourself, the child, and the family. Refer the child to his primary care provider for assessment. Work with your co-workers, supervisors, and mental health consultants.</td></tr>
</table>

Intervene to Enhance Social and Emotional Learning

CCHCs can assist staff in emphasizing social and emotional learning instead of relying on threats, punishment, or social isolation. Social and emotional learning focuses on the development of emotional competence, impulse control, self-expression and self-regulation. Rather than behavior management, caregivers/teachers can instead practice persistent persuasion, patience, empathy, logical consequences, and the combined expectation that children want to do the right thing and that they will also make mistakes.

The focus of this approach is on building an intimate relationship with children that promotes attachment, discussion of emotions, conflict resolution and problem solving skills (Denham and Burton, 2003).

According to Fay and Fay (2005), the key to working with behavior problems in children is for caregivers/teachers to practice the following:

- Keep their own emotions in check
- Respond to misbehavior from a place of empathy for what the child just did as well as the consequences of that behavior
- Send a message that they believe the child can do the right thing
- Gently hold children accountable for their poor decisions
- Provide repetition and practice
- Pay attention to the triggers for behavior and make environmental and interactive changes
- Reserve removal of children to more restrictive settings (time-out) as a last resort

Some additional techniques for caregivers/teachers include:

- Frequently give limited choices in an age appropriate manner: "Would you rather *clean up the puzzles or the dolls?"*
- *Always respond with empathy prior to imposing a consequence: "How sad, I see you grabbing toys from your friends so it is time to make a different choice. This center is now closed for you."*
- Catch the child behaving well as often as possible and notice her strengths: *"Terrific. At this table I see Eric sharing the crayons with Julie."*
- To develop a bond with children, notice them without judging or labeling their *behavior as good or bad: "Bonnie, I notice you have been drawing with yellow a lot this week."*
- Use enforceable statements that tell the child what you are going to do rather than telling him what to do: *"I will speak with you as soon your voice is as calm as mine."*

(Denham and Burton, 2003, and Fay and Fay, 2000, Fay and Billings 2005, Fay and Fay, 2005.)

For example, when a child angrily throws toys, an intervention could look like this:

Caregiver/Teacher: "Hi Johnny, I see you want to come into the block center, but it is full right now. You may ask someone if they are ready to change centers so you can have a turn."

Child: "No! I want to come in right now!" *(Child runs in and knocks down the structure of a classmate and starts to throw blocks at the caregiver/teacher.)*

Caregiver/Teacher: "Oh, no, this is really sad." *(Using her most empathetic voice possible),* "You look really frustrated. I allow children to play in blocks who wait their turn and play safely with their friends." *(Using this enforceable statement in a calm but firm voice while physically assisting the child out of the center),* "Now that you have lost the privilege to play in blocks for today, your choices are art or sand play." *(The caregiver/teacher deliberately gives only two choices where there are openings. It is even better if they might help the child to calm down and self- regulate.)*

Child: "But I want to play in blocks. I hate art! I want blocks!" *(Caregiver/teacher knows this is just part of the power struggle the child is trying to engage her in so she does not enter into it.)*

Caregiver/Teacher: "I know, and that is not a choice right now. Do you want to play in art or sand tray?" *(Said with calm, gentle and firm persuasion so the consequence does the* teaching.)

Child: "When can I play in blocks?"

Caregiver/Teacher: "When I don't have to worry about you throwing blocks or destroying other children's creations. Maybe tomorrow, if I feel that everyone will be safe."

Child: "I won't do it, I promise."

Caregiver/Teacher: "Good, will it be art or sand tray for now?"

Child: "Sand tray. I like to feel the cold sand run through my fingers."

In this scenario, the caregiver/teacher used empathy and persistent persuasion by giving two acceptable choices, using enforceable statements, and letting the consequence do the teaching while holding the child accountable for his behavior without shaming or isolating him. She shared the control by giving him limited choices and allowing him to express himself in ways that did not disrespect others. If a child injures someone, then caregivers/teachers could involve him/her in coming to the aid of the other child. Caregivers/teachers may want to avoid simply having an angry child apologize because, if she/he does not mean it, she/he is just learning to lie and does not develop a sense of remorse.

Develop a Positive Perspective: Usually there is a natural affinity between the caregiver/teacher and children which allows a warm relationship to grow steadily over time. Sometimes, however, a child's temperament or behavior can elicit negative reactions, making it difficult to form a relationship, or the caregiver/teacher reacts negatively to a family or blames a family for difficulties their child experiences. In such situations, caregivers/teachers need to work harder to develop a positive relationship with the child and family. The caregiver/teacher may be able to pick one characteristic that he/she can view positively to focus on.

The caregiver/teacher should make an effort to observe the child's entire range of behaviors. It is important to "catch the child being good" or note what is happening when the child is doing well in addition to what is happening when there are problems. These are the positive behaviors, activities, and relationships that should be encouraged to support the child's success. Every challenging behavior or temperament style can be viewed from a negative or positive perspective. Caregivers/teachers should make the effort to maintain a positive perspective on the children in their care. For example:

- A child who “hits a room like a hurricane” and “bounces off the walls” can also be viewed as “enthusiastic, spunky, spirited, active, daring, and athletic”.
- A child who is “loud and bossy” can also be viewed as “assertive and a leader”.
- A child who is “shy, withdrawn, and fearful” can also be viewed as “sensitive, introspective, and cautious”.

The following tips may help caregivers/teachers respond more positively to children who are evoking a negative feeling:

- Examine their own feelings and understand why they may react negatively to a child or family
- Readjust their perspectives to see the child's and family's strengths
- See the child as capable of developing emotionally and socially
- See themselves as capable of developing a relationship with the child and family and helping to meet the child's needs

If a caregiver/teacher is unable to do this, it is extremely important for him/her to identify another caregiver/teacher who can develop a positive relationship with the child and family.

Adapt the Child Care Environment: Caregiver/teachers must aim to adapt their child care programs (e.g., their interactions with the child, the physical environment, and the activities) to meet the child's needs. The caregiver/teacher achieves a good fit with the child when she adapts her expectations to the child's abilities and helps to guide the child's behavior within appropriate bounds. When the fit between the child care program and the child is right, the child can experience success in his relationships and activities, building his mental health.

For example, a preschooler who fidgets, interrupts, and pokes other children during 20- minute circle time may be showing signs of an active temperament. Talking with the parent/guardian about the child's activity level as an infant and toddler might help confirm this explanation for the child's behavior. Forcing the child to sit still won't change her temperament and may make the child feel unhappy and frustrated. A better response, based on an understanding of the child’s behavior and temperament, would be to provide her options for other acceptable activities at circle time. For example, the caregiver/teacher might say, "You have so much energy! I know it's hard for you to sit still during circle time. If you get restless you can squish and pound this modeling clay." The caregiver/teacher could also include more movement-based activities or schedule a shorter circle time. By modifying the child care activities and interactions with the child to meet his/her developmental and temperamental needs, the caregiver/teacher promotes the child's daily sense of success.

Action Items for the CCHC

The CCHC should:

- Work with the child caregivers/teachers to develop a consistent method for observing and documenting information about social and emotional behavioral concerns and difficulties and for sharing this information with parents/guardians.
- Assist the child caregivers/teachers to develop policies about when and how to seek professional early childhood mental health consultation and how to implement it.

- Ensure that the child caregivers/teachers are aware of important environmental and physiological risk factors and behavioral indicators for social and emotional difficulties.
- Assist the child caregivers/teachers in learning how to interpret problem behavior and in developing strategies for responding to it.

Source Document:

http://www.mchlibrary.info/MCHBfinalreports/docs/U46MC00003/Part2/2-5_m_mental_health.pdf

Appendix 8: Consultation Planner

Child Care Consultation Planner

☐

1. What is a Consultation?
2. Initial Visit
3. Initial Visit: Expert Mode
4. Interim Visit: Developing a Program Improvement Plan
5. Interim Visit: Technical Assistance
6. Interim Visit: Teaching/Training
7. Interim Visit: Referral
8. Discharge or Transition Visit
9. Failure to Progress☐

What is a Consultation?

The section below draws heavily on "Building Consultation Skills," a training module by The National Training Institute for Child Care Health Consultants, Department of Maternal and Child Health, The University of North Carolina at Chapel Hill; 2007.

Consultation is a voluntary process between CCHC and child care provider. It is a problem-solving approach to address immediate concerns, while developing expertise in the child care provider to handle similar future situations independently. The provider may reject the consultant's advice.

Although both parties ideally work together as equals, sometimes the CCHC's expertise drives the decision-making process. This "expert mode" consultation would most likely be required in an emergency or crisis situation where the child care provider needs immediate assistance, such as during an outbreak of a communicable disease. The consultant provides expert knowledge and skills that the provider needs to achieve his/her goals quickly. The need for this expert mode of consultation is usually short-term, and even in these situations, the provider contributes situational knowledge that needed for resolving the problem.

When the health or safety needs of the child care program are outside the expertise of the CCHC, the consultant provides referral to other Child Care Health Consultants or health professionals such as nutritionists, oral health practitioners, behavioral/mental health specialists, environmental health staff or other appropriate service providers.

The American Psychological Association's Code of Ethics (2003) states that professionals should provide services and teaching only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

Initial Visit

Initial Visit is usually an interview. If the CCHC is not familiar with the program, a tour of the premises will be helpful in planning for an assessment visit. The CCHC establishes the goals for the visit.

Goals may include:

1. To describe the role of the Child Care Health Consultant.
2. To Sign agreements and enrollment data forms, including an Information Sharing Agreement.
3. To explore the center's needs and expectations of consultation.
4. To understand the program philosophy e.g., Montessori, Reggio - inspired, therapeutic environment, etc.
5. To gather information regarding the size of the program, e.g., number of children served, ages of children served, children with special health care needs, number of classrooms.
6. To understand the types of families the program serves e.g., military families, children whose fees are subsidized by DES, many children placed for care by CPS or foster children.
7. To determine the program's structure (e.g., school-based, non-profit, church-related, parent board - managed) to determine who else may be involved in decision–making for the program.

Schedule an assessment visit if needed. Early to mid-morning visits allow the best assessment of health and safety practices. Schedule visits at a time the provider does not have responsibility for direct care of children. You may want to leave a copy of the tool which will be used.

AT THE END OF THE VISIT

As you end your visit, summarize what was accomplished at this visit. Schedule the next visit and describe what will happen, who needs to be involved and any records or documents which will be reviewed. Confirm that the provider is in agreement with the plan. Assure the provider has needed contact information should questions arise or if there is a need to reschedule the next appointment.

DOCUMENTING THE INITIAL VISIT

Documentation of CCHC activities (charting) must take place in a way that is comprehensive, systematic and accurate. Documentation provides a description of assessments performed, a plan for care, desired outcomes, and evaluation of the effectiveness of interventions implemented with the program.

Initial Visit: Expert Mode

The purpose of the Expert Mode Initial Visit is to provide expert consultation/advice in an emergency or crisis situation where the child care provider needs immediate expert assistance, such as during an acute outbreak of diarrheal illness. Referral to the CCHC may have come from the child care program, home agency disease control staff, concerned parents, or other agencies/organizations which monitor or provide services in the child care program.

1. Ask the director or staff to explain the problem. Determine who is affected by this problem and how long the problem has been going on. Ask about strategies that have already been tried to solve the problem. Find out if reports have been made to other agencies.
2. Review documentation that may provide more information (injury and/or illness logs, attendance sheets, diaper logs, etc.)
3. Assess the affected classrooms or area. For example, if there is diarrheal disease in the infant room, pay particular attention to the diapering area, diapering supplies and procedures. Review

infant food storage and preparation along with feeding procedures. Evaluate the cleaning and sanitation schedule including management of mouthed toys. Ask about exclusion policies particularly as they relate to children and adults with diarrhea, vomiting and fever. Determine if the illness has been posted or if parents have been notified in writing. If there is an increase in playground injuries, conduct a playground safety check and observe playground supervision habits of staff. Determine that the playground equipment is developmentally appropriate for the children who are using it.

In expert mode, the CCHC recommends interventions which fall into one or more of three categories.

1. **Do these things now** - examples: make the slide off - limits until broken step is repaired; assign a responsible provider to prepare diaper area sanitizing solutions fresh daily.
2. **Do these things soon** - examples: have energy absorbent ground cover tilled to loosen it, have Formica replaced on diaper changing table.
3. **Prevent this situation from occurring again** - examples: create a schedule for regular playground inspections and repairs, schedule a staff training related to interrupting the spread of disease in the childcare setting.

Interim Visit: Developing a Program Improvement Plan

The purpose of this visit is to share the results of the CCHC's assessment, and/or to collaborate with the provider and others who are involved to plan for addressing identified health and safety concerns. It is also an opportunity to begin exploring intervention strategies which utilize the strengths of the program, rely on resources which are available to the program, and can be evaluated. Rules and regulations which apply to the setting and Caring for Our Children should be consulted when developing a Program Improvement Plan.

PROCESS

Ask if the director or others who are present for this visit have any thoughts about how identified health and safety problems might be addressed. Remember this is a collaborative process; the CCHC and provider share the responsibility for finding solutions. Work with the provider to select those issues which present the greatest risk to the health and safety of children and staff for early action. Add additional issues to the planning process overtime. Discuss interventions which seem the most feasible, utilizes the strengths of the program and can be program - driven rather than CCHC - driven. Include a timeline for addressing each problem and evaluation criteria for each problem.

SELECTING INTERVENTIONS

Interventions usually fall into two categories, human or structural.

1. Human interventions are focused on changing knowledge, beliefs, feelings, motivation, and/or behavior. Human interventions include staff training and onsite technical assistance.
2. Structural interventions are focused on changing policies, procedures, and physical features in the child care environment such as re - arranging the diapering area, or advising the purchase of additional energy - absorbent ground cover.

- Referral to other service providers or other CCHCs with needed expertise is also a structural intervention. Whatever the intervention, a timeline and evaluation plan for solving the problem should be developed.

AT THE END OF THE VISIT

Review with the director what each individual has agreed to do. Schedule the next visit and review what is to be accomplished at the next visit. If onsite teaching/training is included in the intervention strategies, determine which room will be used so equipment needs and room arrangement can be considered beforehand. Document the visit.

Interim Visit: Technical Assistance

The purpose of the technical assistance visit is to provide information based on rules and best - practices, to address an identified problem, or to provide leadership in solving a problem. Technical assistance may also be used for offering specific solutions to a specific issue if needed in expert mode consultations. Technical assistance delivery is short in duration (usually 2 or fewer visits) and is customized to meet the needs of the program. An example might be providing information, demonstration and evaluation of return demonstrations related to carrying out safe and sanitary diapering or provider performance of crib safety inspections.

PROCESS

Consider strengths identified for this group in planning the technical assistance. Describe to participants the goal of the technical assistance session, and ask for suggestions for how the goal might be met and what they expect the benefit will be if the goal is met. Providers will resist learning activities they believe are an attack on their competence, so start with what they are doing right. Proceed with activities (demonstrations, policy development, etc.) incorporating recommendations from participants, and acknowledging their opinions and past experience.

AT THE END OF THE VISIT

If the CCHC will return for another visit to continue with the technical assistance process or to evaluate the outcome of the technical assistance, provide, in writing, what should take place before the next visit. Make a note to yourself to call 2 - 3 days before your return visit to provide a reminder of what you will be reviewing and of any assigned tasks that were to be completed. Assure complete follow through with what you said you would do. Document the visit.

Interim Visit: Teaching/Training

Trainings are useful for helping providers improve their skills and learn how to address health and safety issues effectively. Training may be selected as an intervention to address a current need, or for the purposes of health promotion. Health promotion applies to situations where the program is interested in information about the prevention of a health or safety - related problem in the absence of signs or symptoms of the problem. Good training offers fresh and interesting ideas. It also helps providers grow as professionals. Standardized statewide CCHC trainings have not been developed for this project. Every training prepared for an individual program need to reflect the program's unique needs, the rules which govern the setting, local concerns and resources available in the community. CCHCs across the state and across the nation have been very generous in sharing their training curricula for a place to begin. Check

with your colleagues and CCHC project websites. Other departments in your agency may have already prepared trainings that are adaptable for the child care setting.

TEACHING/TRAINING FOR HEALTH PROMOTION

Child care programs often ask for health promotion trainings to assist with meeting training requirements included in their licensing or certification requirements. Proof of attendance at the training will be important. Plan to establish a roster of participants and award a certificate which uses language that matches the training requirement in the applicable rules (for example "Sun Safety" not "Skin Cancer Prevention" in child care centers R - 9 - 5 - 403:14).

TEACHING/TRAINING TO ADDRESS A CURRENT PROBLEM

Training topics and content are often selected by the director in a child care center and do not necessarily reflect the actual or perceived needs of center staff. Within a program improvement consultation visit series, there may be time to determine staff interest. With the director's permission, ask staff members to complete a simple survey. Include open - ended questions. Ask what they want to know more about. You can also list specific topics related to the outcome of the program assessment, and ask staff how interested they are in those topics. If you are working with several family child care providers who share a similar problem, you may find it a positive experience to bring them together for training. It may be validating for them to know others share their experience. It may also be a treat to have a break from the social isolation family child care providers often experience due to their long hours with children in the absence of other adults.

PROCESS

Group trainings may be used as a way to provide relevant information needed to solve a problem shared by participants. Before the training ask how the how the problem is affecting participants and what they already know about the subject. Ask what else they think they need to know to create a solution for the problem.

After the training determine which information needed to create a solution was not included in the training. There are several techniques to make this process more interesting. For an idea, see the KWL table at http://en.wikipedia.org/wiki/KWL_table for assistance in using the KWL teaching strategy. On - site staff trainings usually take place during evening hours or on a Saturday morning. Nap time trainings may be requested by a program, but before the training is planned determine how children will be supervised during training time.

Assure training will take place away from resting children. On - site trainings with staff of a single center offer the advantage of being able to include the CCHC's assessment observations in the center. However, trainings can also be scheduled to accommodate a group of programs with similar needs. Libraries and other public spaces can make space available to the CCHC. A disadvantage of trainings with participants from different programs is the need to maintain the confidentiality of what has been observed in a specific program.

Including a 5 - 10 question pre/post test or other form of evaluation will assist you in determining a knowledge score when you complete your documentation (charting). Testing results can be included in charting the visit either in the Client Specific area or as a note to accompany an interim rating in the knowledge area. There is no system in place to collect pre and post test scores across the state.

AT THE END OF THE VISIT

1. Assure that all equipment including cords, plugs, remote controls and demonstration supplies are packed. Consider labeling cords and remote devices with your name in case they are left behind.
2. Pick up leftover certificates, and handouts, the sign - in roster, evaluation forms, and pre and post tests.
3. Make sure all outlet covers which have been removed are replaced.
4. Assist with tidying the room as needed.
5. Back at the office, clean and sanitize demonstration supplies as needed. Plan to replace supplies which cannot be re - used or are in short supply.
6. Document the Visit

Interim Visit: Referral

When a service needed to assist the program in moving towards established goals is not within the professional expertise or role of the CCHC it may be necessary to refer the child care program to another CCHC or service provider. Before referring the child care program or an individual to any resource, make sure the resource agency and the services offered are credible and appropriate. Be aware of eligibility criteria for services, hours of operation and costs of service. If the referral is for an individual or family, know accepted insurance plans, and languages spoken by the agency staff.

EXAMPLES OF REFERRING THE CHILD CARE PROGRAM TO RESOURCES

The CCHC may be aware that health records indicate that few children in this program have had a first visit to oral health care provider. Many records also lack the name of a dentist. While working with child care staff and AHCCCS to increase children's medical and oral health access, a referral to ADHS Office of Oral Health, local health department oral health programs, or dental education programs may bring services such as oral health screening, fluoride varnish application, staff training on oral health issues, or assistance with establishing a tooth brushing program. There may be a child without access to oral health care who needs treatment right away. The CCHC may consult with the family and assist the provider with finding care or arrange for a referral to a public health nurse for case management services. The event, but not the child's name should be included in the charting.

HELPING PROGRAMS TO BECOME INDEPENDENT

Assist the program to create a community resource file which eligibility criteria for services, hours of operation and costs of services, accepted insurance plans, and languages spoken by the agency staff. Establish a link between the child care facility and community and state resources. This will promote independence for the child care program. Document the visit.

Discharge or Transition Visit

All CCHC relationships will change. Some will end as programs reach their goals or withdraw from a program improvement project, and others will experience a transition as frequent, intense consultation is replaced by quarterly or bi - annual maintenance visits.

Discharge should never come as a surprise to a child care program. For most it will be a celebration of the program's accomplishments related to improvements in health and safety. For a few it will be the result of failure to move forward in the consultation relationship. It may also be that the environment presents health or safety risks for the CCHC, or the program determines they do not wish CCHC services. In all cases during this visit the CCHC should provide the program with instructions for reestablishing child care health consultation services if they will be available.

PLANNING FOR DISCHARGE OR TRANSITION

Discharge or transition from a quality improvement project or expert mode consultation relationship may take place when established goals have been met, it has been determined that consultation is ineffective, or when dictated by project timelines. Ideally the CCHC will determine that:

1. The child care program has the resources needed to maintain the health and safety improvements attained during the consultation process.
2. The child care program will independently move forward to meet goals not yet attained.
3. The Coach has determined that a Quality First enrolled program will not benefit from consultation program at this time or the program does not wish to continue to receive services from the CCHC.
4. The CCHC's home agency policies or guidelines are in agreement that the environment presents health or safety risks for the CCHC. (See the last section, FAILURE TO PROGRESS)

PROCESS

1. The process will need to be individualized depending on the reason the program is being discharged or moving through transition.
2. Review the Program Improvement Plan and what has been accomplished. Identify steps which need to be taken to accomplish goals not yet met if they exist.
3. Discuss potential threats to goals which have been met (high staff turnover, opening new classrooms, changes in population served, e.g., adding an infant room or school - age program) and how threats can be minimized.
4. The CCHC and child care program agree on a schedule and format for maintenance visits. For example discuss what would be helpful to the program, perhaps scheduling communicable disease training in the fall and sun safety training in the spring or assisting with immunization record review in the fall.
5. Provide information related to how the CCHC will or will not be available to the program in the future and how to reestablish consultation services or contact another service provider
   . Document the visit.

Failure to Progress

Not every program will thrive equally in a program improvement environment particularly where consultation is provided by multiple partners and several issues are being addressed in a short time period. Improvements (changes) may come in bursts of activity followed by periods where it seems

nothing is happening. Child care programs which are not responding to consultation despite our best efforts can cause us to throw up our hands and say "I give up!" Not so fast! Giving up is indeed an option but there is often a way to get back on track.

WISE WORDS ON CHANGE

"Change is hard because people overestimate the value of what they have—and underestimate the value of what they may gain by giving that up." James Belasco and Ralph Stayer in Flight of the Buffalo: Soaring to Excellence, Learning to Let Employees Lead "People fear the uncertainties of change. The slightest suggestion that things won't stay the same can cause panic . . . but the real problem isn't the change . . . it's people's reaction to that change." Dr. Alan Zimmerman, Motivational Speaker "Change is highly personal while at the same time deeply imbedded in the systemic structure of an organization. Change is primarily about individuals and their beliefs and actions, rather than about. . .materials, technology and equipment." Dr. Richard A. Villa, Teaching Consultant

WHAT ARE YOU BRINGING TO THE PARTY?

Stop to consider what you understand about your role in bringing about change. You can educate, be encouraging, assist in developing policies and procedures, establish timelines and help create a vision of what might be possible, but the provider is always free to reject your recommendations, or services. You must, however, radiate a confidence that the program can make the needed changes.

INSPIRING CHANGE

While most people understand that change can bring about improvement in their situation or even extend their lives, change is hard! These beliefs must be in place before change can begin:

1. The belief that the consequences of current actions and the current situation poses a threat;
2. The belief that change will reduce the threat. The success of bringing about change depends on individuals' beliefs about their abilities to do the tasks needed to make the change.

SELF EFFICACY

The belief that we are capable of making the required changes is often referred to as the characteristic of "self-efficacy." Providers who believe in their abilities to create a healthy and safe program will approach difficult tasks as challenges to be mastered.

1. They will show interest in the tasks by gathering information.
2. They will put forth great effort to succeed.
3. They will set challenging goals and maintain their commitment.
4. They will find ways to succeed even when confronted by obstacles and failure.

On the other hand, individuals who demonstrate low - efficacy doubt their capabilities and will shy away from taking on a task because they believe they cannot be successful. They may:

1. Shy away from tasks.
2. Give up quickly.
3. Have low aspirations.
4. Dwell on how hard the task is.
5. Focus on adverse consequences of failure.
6. Undermine efforts to be successful.

Low self - efficacy may be situational, that is people who are very successful in many parts of their life may struggle with specific situations. This is easy to understand if you find you are succeeding in your professional role, but the task of losing ten pounds seems as difficult as climbing Mt. Everest! However, some individuals demonstrate low efficacy in nearly every situation in their lives and this has a profound influence on their willingness to put effort into change.

Understanding the way self-efficacy impacts individuals is important for the issue of quality improvement. If providers do not believe a healthy and safe program is important or they do not believe they have the ability to make the changes needed, they can become frustrated with the CCHC's recommendations–and the CCHC may become frustrated with their lack of progress.

Source document:

http://www.azftf.gov/WhatWeDo/Programs/Documents/CCHC%20Handbook3.31.10.pdf

Appendix 9: Case Study: "Eli"

Eli Case Study

Eli is a 2 ½ old boy cared for in a group family child care program in an upper middle class suburb. There are three primary teachers, the owner and two assistants, but it is usually just 2 of the 3 caregivers at the program at a time. This particular program has been in operation for over 30 years. The program is very structured and follows a standard alphabet based curriculum that uses crafts and creative projects to explore the alphabet and promote school readiness.

On one of your routine CCHC site visits to the program, the owner/provider asked you not to go into the napping room due to concerns you would awaken Eli earlier than his usual time. You agree, but asked why this would be particularly problematic. She responded, saying essentially "The less time we spend with him while he's awake, the better."

You chat with the provider a little more about Eli while you continue to check paperwork and health files. Here is some of the information you gathered.

- The provider describes Eli as "destructive" and a "trouble maker".
- The provider has Eli sit is a high chair during meals rather than a booster seat because he won't stay in at the table in a booster seat.
- She said the other children avoid him at meals because he spits and throws food when he is in the highchair.

Eventually during your visit Eli and the other children began to wake up and get ready for snack. You observe the following:

- Eli cuddles with the provider as he wakes up fully and indicates that he needs to use the bathroom.
- He toilets himself independently except for a little trouble pulling his pants up over his pull-ups.
- He washes his hands without reminder a goes to the kitchen where snack is being prepared.
- As snack is being prepared Eli gets more active and gets close to a couple of children, clearly getting in their space, though they react little.
- The provider says "That's enough." Picks Eli up and puts him in the highchair saying "You'll have to sit here quietly until snack is ready."
- Eli starts to cry, says "I'll be good." He eats quietly once given his snack.

You are finished with the paperwork and start to check First Aid Kits and emergency bags in the living room. Snack proceeds quietly until the other children start to leave the table. This is what you observe next.

- Eli asks to get down saying that he'll be good.
- The provider continues to clean up snack and remind children to wash their hands. She does not acknowledge Eli.

- This continues for a couple of minutes and Eli gets more and more upset. He spills his water and pushes food onto the floor. He is no longer asking using words to get down.
- The provider acknowledges the spilled water and food on the floor with apparent frustration and says "I'll let you down once I get this mess cleaned up."
- She cleans up the mess and as she said let's Eli out of the highchair with a reminder to wash his hands which he promptly does and then joins the other children playing.

Just before leaving you ask the provider if she would like to try some things to have a more positive relationship with Eli, like she does with the other children. She replies that she has done everything she knows after 30 years' experience and is doubtful that anyone can help. She reports that his sister was the same way and she eventually outgrew being a trouble-maker too. She figures he will too.

You ask once more if she would like to give it a try. You volunteer that you will be in the neighborhood next week and could stop by again at snack time to see if you could suggest some different strategies if there are difficulties again. She says that this snack time wasn't too bad. She says "He was probably on his best behavior since you were here." But she says that if you are willing to try, she will give you a chance. "What does she have to lose?" she says as you take your leave.

What plans will you make to conduct your visit next week and what do you hope to accomplish??

Appendix 10: Rubric for "Tell a Provider"

Content Objectives

1. Define social-emotional development and describe how it unfolds in the context of caregiving relationships
2. Reframe disruptive behavior as indicative of low social-emotional Health (SEH) and thus a medical concern.
3. Identify connections between low SEH in early childhood and future impacts on the individual and society.
4. Describe how experiences and relationships in early childhood impact brain development and thus the capacity for executive function.

Score to grade mapping rules

The minimum possible score for this rubric is **0 points** and it will be converted to the minimum grade available in this module (which is zero unless the scale is used). The maximum score **3 points** will be converted to the maximum grade.

Content	Covers 1-2 topics, not accurately. 0 points	Covers 1-2 topics accurately, 1 deeply. 1 points	Covers 2+ topics, 2 accurately and 1 deeply. 2 points	Covers 3+ topics, 2+ accurately and deeply. 3 points

Appendix 11: Narrative Version of "Work for Week 1"

The focus this week is to be able to open mental health dialog with providers by explaining how low social-emotional Health (SEH) in early childhood can be a root cause of persistent disruptive behavior, and is thus a medical concern.

You'll begin by creating a "Know - Want-to-Know - Learn" (KWL) chart in a "Wiki" (an online document people can share). This is partly for instructors to know where you're starting from, for your own self-assessment of what this course needs to teach you about this topic, and for a first experience with Wikis (since we'll be using them later).

You'll watch an intro tutorial about the technology, and then create your own Wiki, adding what you Know and what you Want to learn. Then you'll watch Emily's video, and after, key in what you Learned, so your KWL chart is complete.

Then, as a fun "quiz", Liz (our project coordinator) will record herself feeding back what she heard from Emily, but she'll get a few things wrong. You'll find three mistakes and enter them here.

Last, in "Tell a Provider", you'll practice (and hopefully, try out) this new role advocacy.

1. First, you'll compose a "script" for how you'd explain what you learned in the video - either compose it online, or create a document and upload it - here's the assignment. You can also just leave an answering machine message for Bram with your submission (845-750-6204) and he'll save it as an MP3 file. Here's a rubric for that activity.

2. Next, you'll actually find a provider (or someone who can stand in for one) and explain all this to them...and report back to your peers on how this went using our Student-to-Student forum. Please check the other two forums (News & Announcements, Questions & Answers) while you're there to see if important things were shared.

Is this way of presenting the work easier than the outline with time estimates? Please reply in the Q&A Forum if you have a solid feeling about whether the extra work is worth it. Thank you!

Appendix 12: "Linked Activities"

Linked Activities

These activities are part of earlier weeks, but to simplify the appearance of the course, they have been moved down here, but linked to within pages above.

- Course Files Folder
- Course Orientation Video URL
- My KWL Chart Wiki
- Course Syllabus File
- Taking Screenshots Page
- Support Wiki
- 1. The Importance of SEH Page
- 4. Early Brain Development Page
- Upload your PSA Assignment
- Posting Guidelines Page
- Forming a Community of Practice Page
- Links to Resources We Like Database
- Narrative Description of Week 0: Orientation Page
- Narrative Description of Week 1 Activity

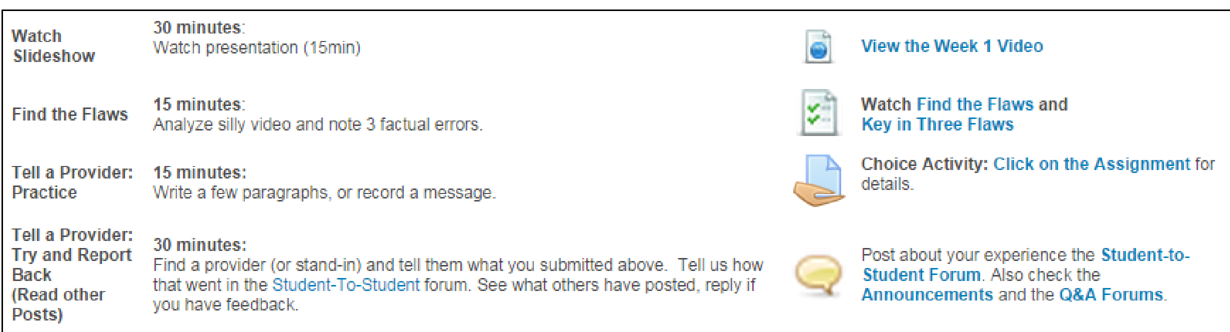
Appendix 13: Week 1 Activity

Objectives (shared with students):

After listening to Emily present this week's slideshow, you will be able to:

1. Describe the connection between social emotional health in early childhood and the short and long term behavioral outcomes for children with social emotional difficulties.
2. Describe how experiences and relationships in early childhood impact brain development and thus the capacity for executive function.
3. Connect Social-Emotional Development (SED) in early childhood to impacts on individuals and society.

“Work This Week” Table of Week 1 Activity



Watch Slideshow	**30 minutes**: Watch presentation (15min)	View the Week 1 Video
Find the Flaws	**15 minutes**: Analyze silly video and note 3 factual errors.	Watch Find the Flaws and Key in Three Flaws
Tell a Provider: Practice	**15 minutes:** Write a few paragraphs, or record a message.	Choice Activity: Click on the Assignment for details.
Tell a Provider: Try and Report Back (Read other Posts)	**30 minutes:** Find a provider (or stand-in) and tell them what you submitted above. Tell us how that went in the Student-To-Student forum. See what others have posted, reply if you have feedback.	Post about your experience the Student-to-Student Forum. Also check the Announcements and the Q&A Forums.

Narrative Description of Week 1 Activity

The focus this week is to be able to open mental health dialog with providers by explaining how low social-emotional Health (SEH) in early childhood can be a root cause of persistent disruptive behavior, and is thus a medical concern.

You'll begin by creating a "Know - Want-to-Know - Learn" (KWL) chart in a "Wiki" (an online document people can share). This is partly for instructors to know where you're starting from, for your own self-assessment of what this course needs to teach you about this topic, and for a first experience with Wikis (since we'll be using them later).

You'll watch an intro tutorial about the technology and then create your own Wiki, adding what you **K**now and what you **W**ant to learn. Then you'll watch Emily's video, and after, key in what you **L**earned, so your KWL chart is complete.

Then, as a fun "quiz", Liz (our project coordinator) will record herself feeding back what she heard from Emily, but she'll get a few things wrong. You'll find three mistakes and enter them here.

Last, in "Tell a Provider", you'll practice (and hopefully, try out) this new role advocacy.

1. First, you'll compose a "script" for how you'd explain what you learned in the video - either compose it online, or create a document and upload it - here's the assignment. You can also just

leave an answering machine message for Bram with your submission (845-750-6204) and he'll save it as an MP3 file. Here's a rubric for that activity.

2. Next, you'll actually find a provider (or someone who can stand in for one) and explain all this to them...and report back to your peers on how this went using our Student-to-Student forum. Please check the other two forums (News & Announcements, Questions & Answers) while you're there to see if important things were shared.

Tell-A-Provider Assignment

Content Objectives

1. Define social-emotional development and describe how it unfolds in the context of caregiving relationships
2. Reframe disruptive behavior as indicative of low social-emotional Health (SEH) and thus a medical concern.
3. Identify connections between low SEH in early childhood and future impacts on the individual and society.
4. Describe how experiences and relationships in early childhood impact brain development and thus the capacity for executive function.

Score to grade mapping rules

The minimum possible score for this rubric is 0 points and it will be converted to the minimum grade available in this module (which is zero unless the scale is used). The maximum score 3 points will be converted to the maximum grade.

Content	Covers 1-2 topics, not accurately. 0 points	Covers 1-2 topics accurately, 1 deeply. 1 points	Covers 2+ topics, 2 accurately and 1 deeply. 2 points	Covers 3+ topics, 2+ accurately and deeply. 3 points

Upload "Tell it to a Provider"

As a way of internalizing Emily's presentation, share what you would plan to tell a provider about how experiences and relationships in early childhood impact brain development and thus the capacity for executive function. This doesn't have to be a formal presentation - can be bullet points.

You can key in the text in the "online text" box below, attach a Microsoft Word document (or any text document) in the file submission box below, or record a message.

If you record a message: If your computer has a microphone, you can record the message in the "online audio recording" box below; otherwise, use Bram's answering machine (845-750-6204) and write the date and time you did that in the "online text" box below.

Student-To-Student (Week 1: Tell a Provider)

by Bram Moreinis - Wednesday, 21 May 2014, 1:00 PM

After you have completed "Tell a Provider (practice), find a provider (or someone you know who could stand for one) and explain what you practiced to them. Then, tell us about your experience here...How did it feel? How did they respond? What did you wish you knew more about?

Re: Week 1: Tell A Provider

by Lana - Sunday, 13 July 2014, 5:25 PM

After watching Emily's video and then the "find the flaws" video, it was very clear what the flaws were! I started to practice the dialogue I would use to tell a provider and then decided "I need to view Emily's video a second time". I was reminded of the time a class participant caught me in error and how careful I need to be.....often there are class participants with more knowledge on topics than myself! They deserve accurate information. Next time I log on I will complete this homework.

I have not yet talked with a provider, but did talk with my son about brain development and SE development. He thought it was very interesting. His wife is a Special Ed. teacher and she is very knowledgeable about a developing child's brain. He felt proud of himself for putting a lot of effort in this area, from birth on, with their one year old son. He listened to his wife who taught him much about this topic, but he said talking with me about it was encouraging and affirming

Lana

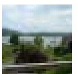
Re: Week 1: Tell A Provider

by Joanne - Sunday, 13 July 2014, 7:19 PM

I have been away on vacation this week so I have not spoken to child care providers. I did speak to my sister who is a 5th grade teacher in a PA suburb. She reinforced for me how early negative events have hindered learning. She spoke about a child who lives in a very poor neighborhood with parents who are violent with each other and move frequently.

However although the child is a slow learner, she trusted mt sister and shared her worries. She was able to form a positive bond with an adult but was a"pleaser". She did whatever my sister or the other kids wanted. She was quiet and did not form relationships with the other children. Another student my sister remembers from this year was adopted from China at the age of 5 yrs. This child is very much a rule follower and very aggressive with rule breakers. She is very much behind her grade level but does try very hard.

My sister acknowledged the importance of early positive interactions to build upon for future social and academic success.



Re: Week 1: Tell A Provider

by Debbie - Monday, 14 July 2014, 11:39 PM

Dear Joanne:

The last line of your tell the provider I thought should be part of our pledge. You really wrote a very concise well written ending I would like to use it as part of our pledge? Please let me know. if you are going to use it. If not I would like to submit it. I would take from the importance of early through success as part of our pledge.

Debbie

Re: Week 1: Tell A Provider

by Joanne - Wednesday, 16 July 2014, 11:06 PM

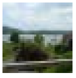
Thank you, Debbie for your comments on my Tell a Provider piece. I agree the last line regarding the importance of positive early interactions are needed to build upon for future social & academic success. If I can figure out how to do it, I will add it. Thanks again!

Joanne

Re: Week 1: Tell A Provider

by Kristin - Monday, 14 July 2014, 2:51 PM

I have not had the chance to "Tell a Provider" yet. However, I know that when I do, I know that I have more information and knowledge to expand on the topic and be able to answer their questions. If their were questions/concerns that they may have that I was not able to answer or feel that requires attention that is not in my area of expertise, I could refer them to our Infant/Toddler specialist for further assistance.



Re: Week 1: Tell A Provider

by Debbie - Monday, 14 July 2014, 8:01 PM

I had lunch with a infant-toddler head teacher and we discussed what I had learned in the first week of class. Janelle (the teacher) is an infant-toddler teacher who has been working in this field for 24 years. She is one of the best teachers I have seen with this age group. Childen attach themselves to her and parents love her.

While I gave an overview of what I learned I found she was not interested. Then I realized I was talking very clinically. Giving her the 700 per second neuron development, Adult child interaction, fact after fact of information did not interest her.

When we started to talk about her room we incorporate information that would be useful to her. I gave her a copy of the vital Signs Supporting Relationship Handout. She then could see why I was telling her about neuron development and the importance of face to face interaction with infants and toddlers. Pruning and strengthening brain development were also discussed. We were able to look at the positive behavior already being done, while looking at some of the Red Flags that were also being done. She told me it was the first time someone had approached her with a suggestion and handouts that were useful and not punitive.

As with myself, Janelle did not realize that at this age children could be under a toxic stress effect, and that we could affect a child for his or her life in such an adverse way.

Janelle admitted that this age group is not for everyone and that she deals with a lot of staff frustration and stress. Janelle stated that in all of the courses she has taken she had never learned or heard of SEH and its effects in brain development. She wondered if it was just another passing fad or study. I told her I hoped not.

Janelle was very interested in the brain development or lack of brain development with children who have behavioral or emotional problems. She had admitted that she was part of the committees who had dismissed children from the program due to behavioral or emotional issues. She said now she would have to think a little differently about how a strict routine or lack of adult /child interaction could have a lasting effect.

Janelle and I talked about what I had seen in the five minutes I observed her before our lunch. I told her she was doing exactly what the positive provider behavior should be. She told a staff member to pick up and cuddle with a crying baby. I told her I was not here to judge her just to give her information on my course. To break the tension I said it was part of my homework and I knew I would see the best practice being implemented in her room.

Once she saw that I was not there to find things wrong she began to ask questions.

Question #1 What happens if you do all of this adult /child interaction in the infant room, and the child moves on to the next room. There is no simulation or adult interaction. What happens to all of the work we did in the first room? I said I believe without the interaction/stimulation the brain will not continue to develop and strengthen its pathway. She stated "Use it or lose it" Yes, but I think it's called pruning. She just looked at me and laughed "there you go using words I will never use again"

Question #2 She stated, if the child moves to another area and does not receive proper stimulation, then returns to the same area one year later with adult/child interaction. Does the brain repair the toxic stress effect and renew and build? Or is the child forever damaged?

I did not have an answer for her. I told her I would find out and get back to her.

I also told her at times she sounded very stressed herself???????? She looked at me, smiled and said "it's been one of those months". I told her to talk to her director or me if she need anything. I told her I have telephone numbers to Rockland's CCRR and others that she may need.

In conclusion: I loved observing Janelle and talking to her. She is a wealth of practical knowledge. She really was practicing adult/child interaction without knowing the importance of it. However, I think she brought up valid concerns 1) Is it a fad 2) Is there going to be training or in-service provided in simple language and practical ways to implement it.3) Is it going to be supported by the director and not used as a punitive solution if you are not providing that type of environment. 4) is it going to be a teaching moment or improvement plan?

I could not answer those questions but said I would pose it to you and get back to her.

Re: Week 1: Tell A Provider - From Debbie

by Emily Leone - Monday, 14 July 2014, 8:44 PM

Debbie- Wow! And thank you for bringing back these excellent questions from your experience. I am going to answer them in order as best as I am able to.

1) Is it a fad? No it isn't though the language may change some as it filters through the system from health professionals and mental health professionals to education staff. There was a very important study called "Adverse Childhood Events" or "ACEs" done by Kaiser Permanente and the NIH. They looked at adults who were sick and dying younger than a similar cohort of adults. They were sick and dying from what the health field would consider to be life choices. Drinking, smoking, drug use, obesity. What these people had in common was these so-called adverse childhood events. Things such as domestic violence, child abuse, neglect and/or sexual abuse, an incarcerated parent etc. Each of these ACEs would count as one. People with 4, 5, 6, or 7 ACEs had medical histories of smoking, alcoholism, substance abuse, heart disease, high blood pressure, stroke, etc. The short of it is, our governments, business leaders, and medical profession are VERY interested in how we can break this cycle and they see high quality child care as one of the ways to help or at least not cause harm.

2) Is there going to be training or in-services with practical ways to implement this? As I think you have started to recognize already, I don't think there is a simple, easy-button way to implement this. Excellent infant teachers like Janelle are few and far between. We'll be touching on this further in the course. I see it more as a practice change within the early care and learning field. So yes, there are resources- especially Infant/Toddler Specialists or Mental Health Specialists depending on where you are in NYS.

And yes, it does take money. 4:1 infant:provider ratios make this type of care very difficult. The state is working on things like Core Body of Knowledge, Trainer Credentials, and Quality Stars NY to standardize high quality care and infuse it into the field. But this is also where we come in. Using the big medical words and being a trusted health professional really makes an impact on some caregivers including parents. Letting them know and reaffirm that the seemingly little things that they do, cuddling, talking with and to babies, make a huge difference down the line in brain development and SEH.

3) The Quality Stars I mentioned above is a way to get those directors who are more concerned about the bottom line in line with focusing on quality care. The idea is that parents choose programs with 4 stars as opposed to a program with one star. The stars are earned through education, training, and implementing high quality practices that are measured using the ITERS-R or other rating systems. Programs with low scores develop plans to improve their programs and thereby improve the

quality. A lot of the measures are closely related to what we are learning in this course. So yes, Directors can be punitive, but the thought is that it will be easier for them to adopt high quality practices since it will result in higher enrollment and happier children & staff.

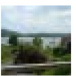
4) I think I answered this one in number 3. I only think it can be effective if it is part of a change in the child care culture. Without a change in the field there will be isolated pockets of excellence, but the remainder of the field will be providing 'custodial' care. I think some of these changes are similar to what we saw in the 80s during the nursing shortage. Pay got better for nurses, so did respect. While it isn't all roses, we saw a big improvement. I personally think that a similar change has to occur in child care. The providers need to earn a living wage and the expectation should be for well educated teachers that are respected for their expertise and skill.

I am going to double-back and get to Janelle's questions about children going in and out of high quality interactive rooms/environments. If you remember the kids in Romania who were raised in the orphanages with little to no stimulation. It didn't turn out great for those kids, but some amount of rehabilitation was accomplished. We, in general, are not talking about that type of situation here, but there are similarities. It is best for babies and toddlers to have their brain development occur in the best way possible for that child's genetic make-up.

If that doesn't happen, rehabilitating and rebuilding the neural pathways can occur, but it takes more effort, more resources, and in reality more money. This is one of the reasons our special ed and school counseling services are so over-taxed. I refer back to the ACEs study. Therapy, counseling, and treating the medical conditions can help adults who have experienced the adverse events in their childhood, but wouldn't it be better (and cheaper) to break the cycle of abuse or whatever it is and thereby maybe not need the counseling, etc?

I hope this helps a bit, and really appreciate that you took this message out to an actual high quality infant teacher and brought back these great questions.

Emily



Thank you

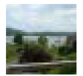
by Debbie - Monday, 14 July 2014, 11:35 PM

Emily:

I will certainly give this information to Janelle. Thank you.

Debbie

Appendix 14: Tooth-Brushing Discussion



Brush your Teeth

by Debbie - Monday, 28 July 2014, 9:23 AM

So glad you found someone who liked to do Brushing of toddlers teeth. Here I usually see stress and loss of patience by the provider. I loved the relationship between the toddlers and the provider. She was warm, encouraging and really looked like she loved her job. She was supervising both children . She was teaching them through song. She even engaged the child who came between her and the sink and never missed a beat in the song. She demonstrated the task at hand in words and song appropriate for their age. She was encouraging. I show no red flags????????

RE: Brush your Teeth

by Emily Leone - Monday, 28 July 2014, 9:24 AM

Debbie,

I agree, I didn't see any red flags with this one. I'm sure you already do this with providers, but you can do like you do with kids and 'catch them doing something good'. It helps to reaffirm that they are promoting social emotional health (and in this case oral health as well), providers positive and specific professional feedback, and helps to develop your relationship with the teacher and program staff,

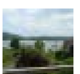
You could say something like "I was so impressed when the other child came up to the sink and you provided him with a toothbrush and toothpaste without even missing a beat in the song! It was so warm and welcoming and had to make them all feel good about themselves as well as learning good self-help skills."

I have to comment on the infection control practices though, even though it isn't a focus of this course. The teacher should apply the toothpaste from a cup or tissue rather than directly from the tube to avoid the transmission of oral germs and saliva from one child to another. I just couldn't help myself.....

RE: Brush your Teeth

by Kristin - Monday, 28 July 2014, 9:24 AM

Emily, your feeling was mutual here.



RE: Brush your Teeth

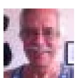
by Debbie - Monday, 28 July 2014, 9:25 AM

Dear Emily:

I too saw the toothpaste issue. I used to buy the cheapest paper cups like the one you put ketchup in when you're at McDonald's. My staff found the cup did not absorb the toothpaste like tissues.

Have a great weekend

Debbie



RE: Brush your Teeth

by Kim - Monday, 28 July 2014, 9:26 AM

toothbrushing without sinks.pdf

I agree with both your and Emily's response. Issues, based on CFOC standards: way too much toothpaste (kids are shown sucking it off the brush), applied from same tube, and kid within two inches of a wall mounted hand sanitizer dispenser.

From an SED point of view, I would argue that sinks be eliminated, and tooth-brushing done as a group activity around a table, with teacher modeling (i.e. brushing own teeth, not just pretending), and facing the children. It goes against eons of cultural practices and assumptions, but makes sense. I've attached a Powerpoint from Head Start that shows how this is done. There are extra HS requirements on there that maybe don't affect you, so you can ignore those.

This is a few years old, and the newest recommendations here in NYC from our pediatric dental best-practices leaders, NYU School of Dentistry, are to a) put the tiny drops of toothpaste along the edge of a paper plate, and the child scoops theirs up as the plate goes around the table (cheaper too!) and b) eliminating spitting into cup (or sink) and simply swallowing. If the amount applied is "rice grain" sized, as Standard 3.1.5.1 describes, swallowing that amount is not going to cause problems (especially compared to the amount those kids in the video are chugging down).

Appendix 15: Instructor Feedback to Week 3

Blue Chair

by Joanne - Monday, 28 July 2014, 9:22 AM

I was impressed with the provider's calm & confident manner. She voiced the statements of each little girl in a factual manner. She stayed on their level. I often see providers try to offer another choice before they acknowledge the original request or give the children a chance to work it out. I did not notice any red flags. The room had other chair choices and activities to allow for options.

Re: Blue Chair

by Emily Leone - Monday, 28 July 2014, 10:55 AM

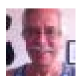
Joanne, I agree. This provider was confident that with support Nina & Xena could manage their time with the blue box. This confidence let the situation unfold naturally while acknowledging Nina's wants and Xena's occupation of the box. I think both children felt a sense of accomplishment. Both experienced some stress, yet it was resolved with support of a trusted caregiver. And as you said, there were other activities and boxes which Nina was exploring when Xena naturally vacated the blue box.

If you saw this interaction at a center you could say something like "You handled that potential conflict over the blue box in a calm & confident manner. Extending Nina's language helped her to express her wants, while also letting her know that you didn't know if Xena was ready to leave the box. You let them work it out by letting Nina explore the other boxes while she waited for Xena to move on to another activity. This allowed Nina to experience frustration and manage it on her own."

Hands On

by Kristin - Friday, 25 July 2014, 4:29 PM

The provider was able to respond quickly and defuse the situation before it got out of hand. She remained calm which in turn the children remained calm. She also encouraged the children to use their own words to express their feelings regarding the situation. Often, we find ourselves asking questions like, "Did that make you mad? or sad?' It's important to phrase the question as an open-ended one, this way the child can learn to express their emotions and thoughts in a positive and healthy manner.



Re: Hands On

by Kim - Saturday, 26 July 2014, 1:46 PM

Nicely said. Agree completely.

Re: Hands On

by Emily Leone - Monday, 28 July 2014, 10:36 AM

Kristin, I agree with Kim- nicely said. There was a lot going on in that very short clip. The provider even echoed the emotion in the little boy's voice when she repeated "I don't like it." This really validated the emotions he was expressing and in turn enabled the Emily to do the same.

If you saw this exchange in a classroom you could say something like "You diffused that situation so quickly, yet encouraged and modeled the children expressing their emotions while preventing further hitting. Having simple rules for what is acceptable and unacceptable expression of our emotions makes it much easier for the children to learn."

Lap Time

by Lana - Monday, 28 July 2014, 9:20 AM

My reply is related to the infant laptime video. I have to say the provider seemed to be relaxed and spoke in a gentle affirming manner which seemed o be effective in gaining the infants trust. The first time I viewed the video, I had it on a very low volume (I could hardly hear it) which enhanced the visual effect. I thought, "The provider is looking at the child, but seems disinterested and bored!"...the child never faces her. When I discovered how to increase the volume on my new tablet, I re-evaluated it and realized that the positioning of the infant actually gave opportunity for the child to explore his environment without the provider being in his face.

Re: Lap Time

by Emily Leone - Monday, 28 July 2014, 10:21 AM

Lana that is an excellent observation about the provider not 'being in the infant's face'. There are many ways that we can affect children's language development and it doesn't always have to be 'serve & return'. In this case you could point out to the provider what she is doing in this situation that is positive. For example you could say "I notice that you are putting words into everything that the baby observes through her senses- what she sees, hears, and even what she is grabbing with her fingers. This will really help her brain development."

Appendix 16: Vital Signs Video Analysis Checklist

Respondent	Response (INFANTS)
Joanne	The provider was on the floor with the infant holding her securely. The infant appeared comfortable, babbling and fascinated with the activity. The provider started to move the infant from the mouth/kissing to finding the eyes, but when the infant returned to the mouth and kissing the mirror, the provider comfortably and calmly switched back to finding the mouth. She used the infant's name frequently. The clip switched to a Hispanic provider and young child reading a book. Although the clip was in Spanish, the provider and child were naming items in the book. They were on the same level, the child could have moved away if he wanted to, and the provider matched the enthusiasm in the child's voice when pointing in the book. No red flags.
Christine	Descriptive language was being utilized with infant but provider was holding infant entire time, not encouraging self-exploration.
Kristin	There was the quiet child that entered the frame of the video and the child was acknowledged but then the attention quickly went back to the other child in the provider's lap. The ignored child then walked away.
Kim	that poor baby was desperately trying to see the caregiver's face
Lana	The provider used descriptive language related to child's movements and activity and also spoke in a gentle affirming manner. She did not appear to be stressed and this lack of stress allowed the infant freedom to explore his environment. He appeared to trust the provider and appeared playfully content. I did not see any red flags.

Respondent	Response (TODDLERS)
Joanne	Provider voice remains calm and matter of fact when potential conflict over use of the blue box. Describes emotion of little girl whose foot is caught on her way out of the box. She is physically on the toddlers level. She acknowledges each child's comments and wants, which seems to help the child feel heard. I did not notice red flags in this scene.
Kristin	The provider was very supportive and responsive to the situation. She was able to have the child identify their emotions in their own words and feelings. She remained calm and defused the situation right away.
Kim	see my post
Lana	The provider remained calm, making no false promises or negative response to the child's upset when saying goodbye to father. She offered apple picking as a distraction or this may even be considered an alternative activity as it took child outside of the walls of the daycare.. I found no red flags. At this age, it is not considered unusual for a child to have difficulty separating from a parent.

Appendix 17: Responses to Case Study (Calvin)

Response to Case Study - Kristin

I would suggest to the provider that she should possibly review the classroom environment. I would make a referral to our Infant/Toddler specialist since she is more familiar with the ITERS and ECERS scales and could assist her in this area. It sounds like the child's frustrations and acting out is due to the fact that the stations are crowded and even as adults, we tend to get frustrated and angry when we are in confined spaces in a store, etc...

I would also suggest that the provider find other ways than time out to manage his outbursts. Time out is an old method and should not be used anymore. Some suggestions here would be having Calvin express his feelings when these incidents happen and to take a step back to see why they are happening. We could review the provider's Discipline Policy and see if that needs to be revised or is the provider in compliance with it.

I believe this provider would require technical assistance as well as the referral to the IT Specialists. She may also benefit from some training on developmentally appropriate activities as well as social-emotional health training.

Response to Case Study - Christine

I would refer the provider to our Infant/Toddler specialist for observation of the class and their recommendations. I would also add that the discipline methods used might not be age appropriate for a 3 year old.

Response to Case Study – Lana

Calvin has quite a bit of energy which seems to cause disruption and frighten his classmates. Things which would be helpful to know:

Have you noticed any change in his behavior following physical activities which may include outdoor activities, dance or exercise?

Has he had any evaluation related to social emotional development or behavioral concerns? If not, parent will need information for referral or given instruction to discuss with child's Healthcare Provider.

Dealing with a child with high energy requires strategies that are uniquely different. Timeout is a very strong method of discipline for these children especially if not given an activity such as a book or stuffed animal. An alternative method of discipline would likely be more effective. One of my recommendations would be working with an infant toddler specialist in creating discipline policies that allow some flexibility for working with children who have behavior problems. These particular children would require an OCFS Individual health care plan with behavior management strategies included. I would also add that the IT Spec could assist with providing recommendations for a room arrangement that would eliminate crowding and isolation

Care provider education in working with children with challenging behavior would be a very appropriate call.

Response to Case Study – Debbie Gianelli

The case study with Calvin is the most common problem in toddler care. The frustration is palpable when you have a child like Calvin. The provider is stressed due to the inability to control; her class. The children are on edge fearing they will be the receiver of Calvin's wrath. The director is on edge because the parents in the class are waiting for the director to do something. The parents are also threatening to take their child out of the program for not providing a safe and secure environment for their child

Next I would suggest to the parent's is he exhibiting the same behavior at home. Is he put in time out at home? How is that done? I would also ask the parent has the child's hearing been tested? I would also start explains what an evaluation is and what the components of testing entail.

The director should also give the parent an outline of what they will try and if it does not work maybe this type of childcare is not for Calvin.

The first issue I would deal with is the director. She is the person who has to deal with the parents and the teacher. I would first see if she has looked at the schedule in the classroom to see if the scheduling is appropriate and flexible for the age group. I would then ask her if she personally observed the running of the classroom. I would see if she felt a change in the environment was necessary since this age group needs lots of space between activities so children do not bump into each other or feel cramped.Or does she want some help from an Infant/Toddler Specialist? I would also tell her to collaborate with her local CCRR to see what programs are being offered for infant/toddlers.

Then I would point out the frustration and stress level of both the teachers and staff due to Calvin's behavior. I would recommend that an I/T Specialist along with an environmental specialist be brought in as an in-service. The specialist should be as a teacher and collaborator. Not someone just to give her point of view or tell the staff what they are doing wrong Also the director sets the tone and should have a meeting or round table where all staff can discuss openly their concerns about Calvin. It should be stressed by the director that Calvin is not an isolated situation. There will always be a Calvin in your group. What we need is solutions and techniques that are age appropriate for the toddlers.

Lastly, shadowing Calvin to help prevent the other children from Calvin's tossing and hitting etc.

Response to Case Study – Joanna

I view my role to be a collaborative consultant working with the provider/teacher AND an advocate to both the adults and the child. The problem seems to be that the child can be physical with the other children and not listen to the directions of the teachers. Also, the teachers seem to instruct Calvin on what NOT to do. They also expect Calvin to behave poorly. Lastly, the classroom environment appears crowded with little personal space at the activity stations.

TA or modifications I would recommend are:

1. Review the environment and rearrange the activities so that the children maintain personal space and be sure the room has enough toys & supplies for the children.
2. Model verbal observations of Calvin performing good behaviors i.e. "I saw you walk slowly to the blocks, Calvin." with a smile.
3. Review use of time-out and model how a peaceful "re-grouping" space would more quickly defuse the situation.