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HEALTHY COMMUNITIES

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Mental Health Consultation in Early Care and Education Program

SUJATA BANSAL: Okay. So, we're going to start. We're talking about what is early care and education mental health consultation. As Jane said, this is a relatively new filed that's developing and it's growing, and so really we're sort of on a continuum in learning to do—provide mental health services to early care and education. And in essence, they are preventative in early intervention services for children, families and ECE staff that promote social-emotional wellness. And we're looking at the social-emotional wellness, if not just the children in the families, but really the social-emotional wellness of the classroom environment and everybody in that environment. In order to talk about it a little bit better, we break up those services into five main areas, and I hope that people were able to pick up the handouts in the back because there's a handout that has detailed definitions of each of these areas. So I'm not going to read through what those definitions are, but instead I'm going to offer a little vignette to sort of illustrate how early childhood mental health consultation might work in a classroom.

So, typically, consulting gets involved with the classroom when there's a concern around a specific child, and usually it's external or acting out behaviors that really draws the attention of a teacher. So, here's a very common scenario. We have a

teacher, Ms. Mona, and she is frustrated by three-year-old Samantha's behaviors at circle time. Samantha's fidgety. She disrupts circle time and she tends to invade the space of the other children during circle time. So, Ms. Mona asked the consultant, Natalie, if she could help, and we're going to assume that there's parental consent and permission before the consultant helps. The consultant might spend several days and weeks making observations during different times of the day. We'll also talk to the family, talk to the teachers to find out everybody's perception of the situation, not just one teacher. And during her observations, Natalie does notice that, yes, Samantha does exhibit the behaviors Ms. Mona talked about, but she also notices a few other things. She notices that Samantha often arrives late to school, and so her transitions are rushed. She notices that Samantha's father sometimes doesn't have time to say goodbye to Samantha, and she also notices that the circle time right before—I mean, the transition right before circle time is not very smooth, so sometimes the teachers aren't sure who's doing circle time that day and the kids aren't always sure what's happening. So, Natalie, the consultant, might address the situation in a number a ways. Certainly, the concern came in around a specific child, which we would put under child specific consultation, but the consultation work is really on all levels. Natalie might offer some suggestions around why transitions are really important for young children and how routine is important, and those are suggestions that teachers might implement throughout their program that not only affect Samantha but affect all of the children in the program. So, by that, that's sort of a--more of a general consultation that is a suggestion that affects

the classroom in general. She might make a suggestion to move circle time to a little bit later in the day because maybe several kids are running in late and so that helps the program flow better, so that would be a programmatic suggestion. She might have some child specific suggestions of talking with Samantha's father and finding out what's going on at home and what's making it difficult to get to work—get to school on time, and depending on what she learns she might have some suggestions for what Samantha's could do to help Samantha, maybe some suggestions around how he can really say goodbye to Samantha before he leaves and why that attachment is so important. So, that's just a scenario of how a consultant would work in the classroom on various levels.

Really when we're talking about mental health consultation, it started off historically as a child specific service. And what we've come to find is that if you work just with the child but don't really address the other needs in the classroom that we don't see sustainable change. And so what we try and focus on now are more—one and two, the general and the programmatic consultation as what we see to be—what you would call best practice or really effective consultation.

Okay. So, although I think this is a quite experienced group, some people might be wondering about, well, what is the need really out there, and could young, little two, three and four-year-olds really have such intense needs that they would require the services of a mental health person. And I see a lot of heads nodding, but I want to show a very short video clip. This is a video done by Project

Relationship, a program of WestEd, and they talked to several different ECE providers to hear what they have to say.

UNIDENTIFIED SPEAKER: Twenty years ago, I have a three-year-old come up and say to me, “My mom has a gun in the car.”

UNIDENTIFIED SPEAKER: I would say about 50 percent of them are children of teen parents.

UNIDENTIFIED SPEAKER: Grandparents are taking the responsibility for their children’s children.

UNIDENTIFIED SPEAKER: Parents are working, they’re working parents. That’s how our society is.

UNIDENTIFIED SPEAKER: It’s very common to just have drugs on the playground for a child to find a syringe or find a needle or find a little bag of pot, come running in with, “Look what I found,” or bullets. All of these things you didn’t have them 20 years ago, at least not to the degree that you have them today.

UNIDENTIFIED SPEAKER: An area with a lot of (inaudible), a lot of retaliation, murders back and forth.

UNIDENTIFIED SPEAKER: One-parent family situations.

UNIDENTIFIED SPEAKER: More complex society needs a place in the family and the increase in the number of families that need child care.

UNIDENTIFIED SPEAKER: It comes down in their play.

UNIDENTIFIED SPEAKER: In the block area outside, we might see them build a bus and a staff member asked them where they're going, they might say to the (inaudible) another town, we were having a fundraiser, and a little boy just announced to the staff that his father could not sell those things in jail because they didn't (inaudible).

UNIDENTIFIED SPEAKER: Poverty, domestic violence, lack of access to health care, and discrimination are some of the factors creating stress in the lives of children and adults. Early childhood educators are faced with the ongoing challenge of providing a supportive, responsive environment for young children and their families who have diverse special needs.

UNIDENTIFIED SPEAKER: Now more that ever, very many very young children are spending long hours in child care programs. Some are in the programs from dawn until dusk, which means the majority of their waking hours is spent and out

of home care. This means that the child care center now more than ever need to really address the social-emotional well-being of these very young children.

UNIDENTIFIED SPEAKER: If children don't trust then they're not going to be able to learn, and they're going to be able to take risks, they're not going to be able to practice and master things. We need to help educators, early childhood people understand why making a relationship is important. And the way we do that is that we spend time, get to know children, and help through the relationship to make sense of the world around them.

UNIDENTIFIED SPEAKER: But we're based with, I think, an even more complex challenge, and not only as staff really not trained to work with young children, their families, but they're not trained to deal with the multiple needs that those children and young families bring with them.

UNIDENTIFIED SPEAKER: The teacher training programs have taught techniques and they've taught (inaudible), but they haven't taught relationships. They haven't taught the goal between individuals that enables people to form bond.

UNIDENTIFIED SPEAKER: I am in awe of the kinds of responsibilities that we give to staff with regards to helping support families in raising their young children.

UNIDENTIFIED SPEAKER: Let me help you a little bit. Okay. Let's do it together. We're going to do it together.

UNIDENTIFIED SPEAKER: Project Relationship was developed in--

SUJATA BANSAL: Okay. So I think the video did a really nice job of talking about what the need is on its own, and the slide is just reiterating what you heard from the actual ECE providers themselves, but basically that providers don't have the training to deal with the high-stress issues that kids and families are coming in with in this day and age. And that's just because that's not traditionally what they've been trained to do, and that our times are changing and providers then have to take the (inaudible) of that, and they're often already overworked and underpaid and really struggling with staff moral issues, and so it's even more pressing given the issues that kids come up with. And one of the things that is really alarming that we're seeing is that kids are also being expelled at two, three and four from preschool, and that's an alarming trend for many reasons. And I'll let Jane talk a little bit more about that.

JANE BERNZWEIG: Okay. Some of you are probably familiar because I saw that—I guess I presented last year at AMCHP that Walter (inaudible) studies on preschool expulsion. And here we're showing that it's about three times that preschool children are expelled from programs about three times the rate the

children in elementary and higher, K-12. And the reason this expulsion issue, I mean, clearly none of us want to be expelled from places where we are, but for children it's particularly bad early on to be faced with this kind of challenge. It sort of builds a negative feeling about school that probably doesn't go away easily when it starts so early. Their self-esteem is probably affected by this. And that what's—the disruption just in terms of relationship development that children are doing at that age and how important that is for their development is really obviously disrupted and—but the good news because I feel like we're telling all these sad stories now, but the good news is that it's been shown, I believe, the studies have shown that this early intervention approach of classroom-based behavioral consultation, mental health consultation has really decreased the likelihood of expulsion, the rates of expulsion, and has increased some school readiness kinds of things where the kids are doing better and ready for school.

So, I want to now, with that said, a little bit more positive, is talk a little about our program, First 5, and those of you may know that it was created by the voters, a proposition, Prop. 10 it's called by the voters in California 1998, and it is—well, it actually is a revenue is tobacco tax. I think it's $0.50 on whatever it costs--I don't know—for a cigarette—for a pack, not a cigarette but for a pack. And the goals of Prop. 10 are to support health, well-being and school readiness of children zero to five, their families and the providers who serve them. So it's really all aspects of the zero-to-five development. It's actually not here but that 80 percent of the revenue goes directly to the counties, so—and we are one county, Alameda

County, and each county develops a strategic plan, and our plan is called Every Child Counts, so that's who we are basically.

I wanted to give you an overview of the demographics of our county. And I want to start this by saying I'm going to show you about three slides that it's a very diverse county in terms of race ethnicity, economics. We're in the San Francisco Bay area. The total population based on the 2000 census was 1.5 million children. It's people. I'm sorry. You're right. Thank you. Right, 1.5 million people. It is quite urban, would you say. We have a little bit of suburban areas out there. But there are about 125,000 children ages zero to five, and these are 2007 population estimates and approximately 20,000 births per year. And again, just to reiterate in terms of some of the diversity issues that many children, they enter school, they enter kindergarten, there are over 50 languages spoken by these children, not one child, but language. And 37 percent of children speak a language other than English.

UNIDENTIFIED SPEAKER: The slides go a little bit out of order (inaudible).

JANE BERNZWEIG: Yes. Thank you. Yeah. We decide to put all the demographics together kind of flow in that sense. So, the next is to give you a profile of the—what ECE programs look like in the county. This is based on data that we have from the Center for the Study of Child Care Employment in 2006, which is at UC Berkeley. And there are about--well, you can see the second

bullet there's about over 4,000 center-based programs in the county, and about over 2,500 licensed family child care providers in the county. These are licensed programs that we're presenting. The important thing, too, that we want to point out and I think I'll just mention, that these programs, the center-based programs, or 60 percent of those programs receive subsidies for children. That's not children in the care, but those are the number of programs. And 41 percent of the licensed family child care providers receive subsidies, and for the center-based programs, it's Head Start, early head start in state preschool. And for the family child care providers, there are alternative payment programs, welfare work, CalWORKs as it's called in California. But just to remember, and this may be true in other states as well, that these are all need-based, income-based programs obviously. Head Start is 100 percent of poverty, so in other words, to be eligible for Head Start, I think you have to be in a family of four and earn under $20,000. So, in California, this is a problem. There's a lot of children living in poverty and they're not eligible for some of these subsidized programs. So, we think that these data are sort of showing the disbarrier, the tip of the iceberg for the numbers of children that really may benefit from subsidized programs.

Okay. And one more. One more slide. And we'd like to just give you a feel for the race and ethnicity, again, speaking to the diversity of our county. One important thing that I'd like to share right away is that the dark blue bar in the first—okay. First of all, let me just tell—the light purple bar are ECE providers, the race and ethnicity ECE providers, the dark blue bar are mental health providers, and the

yellow bar are children. And one important thing to note is the—I think it's 14 out of the 22 mental health providers are White. So, the majority of the mental health providers and the ECE providers are very different. Their racial and ethnic backgrounds are really different than the children that are being served and the growing population of children zero to five. If you look the largest bars for the children are the Hispanic Latino children and the Asian population, and that is expected to grow even more by 2010. They will be the majority of children in our county. Okay.

SUJATA BANSAL: Okay. So now that you know a little bit about our program, Every Child Counts, and our demographics, let's move on to talk about some of the approaches that we've used. Someone in the audience had talked about their—hoping to learn about how we've built this system of early childhood mental health. And so, these are really what we've identified as important components to building a system of mental health consultation to child care. And first off, I just want to mention that the prevention identification in early intervention is especially important. That's sort of the premises of why we are advocates of early childhood mental health just that if we can identify and catch issues early, not only does it mean that it's likely that kids don't continue to have problems, but if they did that they are less severe. And so that not only benefits the child, of course, but the family, the system, all of society benefits from that. Unfortunately, we tend to live in a very treatment oriented culture here, and so we're really trying to shift to that focus to look at early intervention. At the same

time, once we've identified those kids we need to have a place to send them, and if we don't then we've identified kids and can't do anything about it. So, a really big part of what we do at Every Child Counts is a lot, a lot of training, and we try and train providers so that they can meet the needs of the kids that we identify. We've said a couple of times, somewhat of a new field and so we often don't have people who are very well-versed in what it is that young kids age zero to five need, what are the issues that we see in child care and such, so training is a large component. Our commitment to systems changes just that we know, and you all know, that you can't pull a child out, fix them, and send them back to—well, first of all, there's no fixing of the child, but most of you can't send them back into a dysfunctional system. If you do that then the changes aren't sustainable. And so we really look at needing to approach the issues at all levels looking at not only the individual child but the system that they're in. And so, to that effect, we are very committed to partnering with community agencies within Alameda County and work very collaboratively with them to look at how we can affect change across the board.

Of course, promotion of best practices is something that we hold dearly, which is that we want to make sure that what we're practicing is—that we have some standards around that and that they're considered to be good practices for the kids, all of the kids that we serve given the diversity that we see. And then a lot of what we do is we look at what are the programs that currently exist and where are the gaps in those services. And when we see a gap that needs to be filled,

luckily we—because of our funding source we are able to create new programs and pilot new programs, which is very difficult to do and very expensive, but we have the infrastructure to do that. And then we also have a—in house eval and tech, which Teddy leads where we can evaluate the programs and see are they effective, are they not, and what needs to be changed. And that's really a very critical piece to systems change. And then finally, developing a common language so that we can communicate with each other, so that when I say early childhood mental health, and you say it, we mean roughly the same thing.

So, I'll be referring to the strategies as I walk you through some of the programs that we've created around early childhood mental health consultation. So, I'll be going through—or Jane and I, we'll be going through these four main programs which are very specific to mental health consultation to child care. First one I'm going to talk about is our early childhood mental health systems group. That group is part of our larger Alameda County Child Care Planning Council. How many of you are familiar with—or have a child care planning council in your counties? Oh, okay.

UNIDENTIFIED SPEAKER: We do.

SUJATA BANSAL: So, you do.

JANE BERNZWEIG: In Florida?

UNIDENTIFIED SPEAKER: Yeah.

JANE BERNZWEIG: Do you know if it's statewide (inaudible)?

UNIDENTIFIED SPEAKER: (Inaudible).

SUJATA BANSAL: Okay. So, the Alameda County Child Care Planning Council is basically an advocacy group comprised of various community child care stakeholders, and really what they're trying to do is advocate and affect policy that involves children and child care or child care situations. They're often looking at things like quality of child care, what is the need, supply and demand, and they're very active with our local government to make sure that new policies that are coming out are to the benefit of kids in child care. So, the child care planning council has various subcommittees, and one subcommittee is the early childhood mental health systems group, which is very focused on looking at mental health issues in child care, and it's comprised of ECE providers, mental health and other folks who might be interested. Sometimes we have community college folks come, someone from Jane's department, eval and tech, may come, and they're looking at the overall system of mental health and in child care, and what they can do to create more acceptance of mental health and child care. One thing that they worked on intensively—this was about a year and a half, two-year project—was to create standards of practice document. So, a couple of slides ago, I talked

about the common language in creating standards, and what we found was that people were out there doing the work, they were doing consultation work, and they were all very individualized. They weren't networking with each other, they weren't talking about what they were doing, they all had their own way of doing it. And so we felt that it was really important that there were standards so that when someone said they were a mental health consultant, that we could be fairly certain that they held these principles near and dear. And the one that I'm going to just spend a little bit of time on is really relationship-based because that is at the heart of what we try and do with the providers, with the teachers, with the children, and its relationship between the consultant and the teacher, teachers and teachers, teachers and parents, teachers and kids, so it's really all relationships. And that those relationships should look at all of these other points that they should be mindful of these other points, and without that there—without that relationship and without a healthy trusting relationship, we can't progress.

So, creating this document and coming to an agreement on it, as you can imagine, was quite a process but we're very proud of this now. And the second achievement of the systems group was to create county-wide symposium where we bring together mental health and early care and education providers to strategize and talk, and support each other, and learn about what each other does. And there's a challenge in this partnership between mental health and early care and education, and those of you who are familiar with the work, can

you tell me what some of those challenges are in that partnership? Why do you think that's a difficult relationship? Yeah.

UNIDENTIFIED SPEAKER: We have different disciplinary perspectives and in particular, mental health is—seems I think—sees itself as more professional versus the early care and education community which may—like professionals, too, but not with the same degree of credentialing and training, and so there's a sort of a power and (inaudible).

SUJATA BANSAL: Absolutely, beautifully said. You hit the nail on the head. That is a huge reason that there is this disparity or this difficulty. Any other reasons why the relationship could be challenging? It's a hard act to follow. Okay. So, definitely what the—I'm sorry, what's your name?

DEBORAH: Deborah.

SUJATA BANSAL: What Deborah just said is really the crux of the matter. There are those disparities, and they exist in professional training, in education, in race ethnicity as you saw earlier. We don't have consultants that match the racial and ethnic backgrounds of the providers, and that can cause a lot of disparities. Class is a big issue. Often your mental health consultants have master's degrees and get paid much better than your early care and education professionals do. So, this symposium really brings these groups together and starts to have a dialogue.

Some of our themes, so we're on our third year now, and the first year, our theme was finding a common language. Second was what do we need from each other to make this relationship work, and our third one which is actually in two weeks, is going to look at how the two professionals can partner together to support parents, so we're finally ready we feel like to bring in the parents now. Okay. Any questions or any (inaudible) before I go on? Okay. Feel free to—

UNIDENTIFIED SPEAKER: You like the monkeys, right? (Inaudible).

SUJATA BANSAL: Monkey puppets, yeah. One of our second strategies is our mental health partnership grants, and these were two two-year grants that ran '03 to '07 which were awarded the first—'03 to '05 we had five agencies that we funded to provide mental health consultation, and '05 to '07 we have four agencies. And basically we funded the agencies to provide services to child care site, but at the same time we also asked them to participate in a very, very intensive training. And I say very, very because I trained them and it was a lot. We started off with 20 hours a month of training, and slowly waned from that. So now we're in year four and we're down to six hours a month of training, which is still intensive. And really it was because, as I said before, people were out there and they were doing their separate thing, they weren't communicating, they weren't networking, and we really wanted to bring this community together and get them at the same table, and make sure that people were agreeing to a certain standard that they were networking, that they were supporting each other,

and that they had colleagues that they could talk to and to help them understand the work, because the work is challenging. I keep saying it's sort of a new field, and so we felt really important to us to create that for them. Yes.

UNIDENTIFIED SPEAKER: Did you require that a mental health consultant has a master's degree in mental health (inaudible) this is probably the most intensive training I've heard of, these kids of programs, and I'm wondering also if you had a certain level of credential that you are expecting on these people?

SUJATA BANSAL: Yes, exactly. We do require that they had a master's in psychology, counseling, or a related field, and that they were supervised by somebody who also obviously had that and had been supervisor, but again, because it was a new field we couldn't really require that people had years of experience or anything like that because a lot of people are coming in brand new, brand spanking new. So, as we've grown and as we've developed more capacity, we can up the requirements. And one of the things, just an interesting side note, is that—and is might come from that I have a background as a teacher but I do feel that it doesn't necessarily have to be someone who has a strict mental health background. I think someone, a mentor teacher, for example, a teacher with a high level of training and experience themselves can also participate in something like that. And this year we have somebody who has a master's in child development and she's doing really well in the program. So it's sort of been a growth for us.

JANE BERNZWEIG: Okay. We want to give you an idea of who we served and how many we served, and in this slide they are really quite over the course of the 2003 to 2007 period that there have been about 1,000, if you had across, about 1,000 staff that have received services, and I think almost, let's see, 6,000 children, something like that. So, quite a few we've had an impact, and the thing is, too, that many of the agencies that are part of our partnership grant would not have been able to provide this level of service had they not at this program, so (inaudible) these ECE programs.

Okay. Now, this next slide is our favorite slide. So, I want to hear from you. As we talked, well, Sujata started, she really talked about what our goals were ultimately, again, to move from child-specific consultation to more classroom-based consultation, and then she pointed out that what's really important is that you don't want to bring your child back into a dysfunctional environment, and in terms of sustainability that the environment is so important. So, overtime if you look at the yellow bar shows a decrease in the amount of child-specific consultation relative to the amount of classroom-based, what we call general and programmatic consultation. And so, the third—the 2005, 2006, which is the last period that we've fully collected data on that year, we have really seen that shift occur clearly, so that's why it's our favorite slide. Yeah.

UNIDENTIFIED SPEAKER: Can you talk about having (inaudible) to gather those data (inaudible).

JANE BERNZWEIG: Yes, now I'm laughing because that's one of my jobs directly so that's good. Actually it's really great. Since I've been here almost about a year and a half now, the data has been all electronic. I guess it's the best word to—we have an online reporting system so we've trained all of our agencies. Remember its four, five agencies that we're dealing with. We've trained them to track the common information from each agency. So what's really great is we can get—we hope to get the same kind of data reported by each agency so we can actually—those definitions who (inaudible) spends a lot of time going over to make sure we're all seeing consultation in the same way. Those of you, like research people who--sort of standardizing these sort of concepts so that everybody is seeing it similarly. And we spend a lot of time; we give them a lot of technical assistance to do that. But now it's all electronic so it makes it easier to get numbers out and stuff. Does that answer your question, sort of, or is that--?

UNIDENTIFIED SPEAKER: Do you think (inaudible)?

JANE BERNZWEIG: Yeah. Well, for our purposes we have—they report twice a year for us, midterm and end of year. And so we ask them for totals for this kind of date, for each of these periods. But some of the things--we do ask about like

how many children have you served, and number of providers, number of children, how many children for those who are doing more treatment-related or child-specific, we ask them how many children are getting play therapy, and what's the average number of sessions, I think, and—go ahead, Teddy. Teddy might be able to speak to this even better because she developed the system, so.

TEDDY: Well, I think if I'm getting the question is—what I think you're asking is how the (inaudible) agencies have, and they're really trying to (inaudible). There's one agency that is (inaudible) and they have a very meticulous tracking form that they required each (inaudible) to complete. Other agencies just have—each consultant has their own (inaudible). But the key to it, and it's not going to Starbucks getting them to differentiate between (inaudible).

JANE BERNZWEIG: Yes. Yeah. I think we're getting at something because this is where we're moving and this data is showing that. So, we feel pretty confident that we're on the same page, so. Okay.

SUJATA BANSAL: So aside from tracking numbers, we also try and look at other outcomes and changes, and we--again, we have our internal eval and tech department which holds of us accountable and we have to hold all the grantees accountable so that we can write all of this up in our annual reports. So some of the outcomes through the mental health partnership grant are listed here. These

were some of the things that we saw happening through this work. And so, some of you volunteered or were asked to volunteer, to read quotation for us, so if the first person for slide 17 can stand up and read please? Slide 17, so I think it's the lady in the back.

UNIDENTIFIED SPEAKER: No.

SUJATA BANSAL: Does yours say elephant on it?

UNIDENTIFIED SPEAKER: (Inaudible) slide 17?

SUJATA BANSAL: Number one?

UNIDENTIFIED SPEAKER: Oh, number three.

SUJATA BANSAL: Okay, yeah, so number one please.

UNIDENTIFIED SPEAKER: We have built a rich network of contacts within the early education of early intervention communities, and enabled us to work effectively in supporting young children's possible development. This networking has facilitated referrals and resource sharing.

SUJATA BANSAL: Great. Thank you. So I was going to ask you guys to guess under which category it falls but she said the word networking twice, so. Again, the networking was so important to bring the agencies together and give them a chance to meet each other and support each other because it's hard work, and just like anything it takes a village, so creating the network was extremely important. Slide 17 number two. No, slide 17, yeah.

UNIDENTIFIED SPEAKER: (Inaudible) also opened (inaudible) and extremes for us so that we've been able to (inaudible) and increase services. This new term position (inaudible) to receive an APSAT contract, which has completely (inaudible) the department has run through a new Federal (inaudible) funding, we have now begun to expand our consultation services too.

SUJATA BANSAL: Great. Thank you. Again, so that falls under sustainability. And so, again, one of the important things is once we're not able to continue funding these programs, we're worried that who's going to—the services are still going to be needed, and so what are they going to do? So one of the things we really push the agencies to do is to secure outside funding to become sustainable. And many of our agencies actually have been able to do that, again, through networking, which has helped them say—hear about, oh, you got funding from such and such organization, let me apply for that, and sometimes they may collaborate and apply together. Yes.

UNIDENTIFIED SPEAKER: And what is the current fund (inaudible)?

SUJATA BANSAL: For these agencies? It's 75,000 per grant year, so 150 for the two-year contract or two-year grant. Okay. Slide 17 number three.

UNIDENTIFIED SPEAKER: Our biggest achievement is the establishment of a multicultural (inaudible) team of supervisors and interns. We're proud to be represented by four Latinos, an African-American, a Chinese-American, a Lebanese, a lesbian, two male and six Caucasians. Languages spoken are Spanish, (inaudible), Cantonese, Mandarin and English.

SUJATA BANSAL: Great. Thank you. So again, you saw the diversity sides that Jane showed you earlier, and it's so important that we're able to meet the cultural language, ethnic needs of the providers, and so we really emphasize that these agencies secure folks who can do that by culture who are bilingual who can meet those needs. Slide 17 number four.

UNIDENTIFIED SPEAKER: (Inaudible) strategies (inaudible). We can see a big difference in this child (inaudible), and once this child (inaudible) and say, well, how did you handle this? How did you do this? How did you deal with it? And we kind of give them ideas of what we did and stuff. It just goes to show how (inaudible) and strategies we had (inaudible).

SUJATA BANSAL: Thank you. So, that was clearly a quote from one of the teachers directly. The other quotes were from mental health agencies themselves. So again, being able to tell a teacher that they will see changes in the child's behavior is sort of the magic bullet, right? I mean, that's what they're really looking for is that will this child behave differently. And so, to be able to demonstrate that and to have this teacher have that experience was very empowering, I think. Number five, slide 17.

UNIDENTIFIED SPEAKER: Teacher (inaudible), as a teacher it is always helpful to have someone else to help the parents and their children, someone who's not so close to the problem. And this intern must be sensitive to the needs of each child

and willing to assist whenever problems cause disruptive behavior in the classroom. And the intern helped me overcome difficult situations (inaudible) to report abuse to the Child Protective Service. Their support and guide has helped me to understand what steps I should do to support the child's (inaudible).

SUJATA BANSAL: Thank you. So that one's powerful because having to report to Child Protective Services, and I know it's called different things in different states, but that's an extremely difficult task for anybody, and teachers are often faced with that, and they feel very alone. I remember isolation was one of the words that was up there. They feel very alone, they feel like they might get backlash for doing that. So, for her to have the support from a consultant and to

feel empowered to do that and feel like she could trust this person to support her through that was important for this teacher. So that demonstrates the relationship building. And then finally, slide 17 number six.

UNIDENTIFIED SPEAKER: (Inaudible).

SUJATA BANSAL: Great. Thank you. So the expulsion rates that we talked about earlier mean this was a child that would have—was on his way to being expelled, that with the work of the consultant, they were able to strategize and keep the child in school, and now the teacher feels proud of that. And so, just her understanding of how to address the challenging issue was improved. So, these are some of the outcomes that we're particularly proud of with this program.

JANE BERNZWEIG: Another program we had was called the Early Learning Opportunities that—which is an 18-month program between the child care planning council and the community agency called Safe Passages. It was funded fairly by the Child Care Bureau, and it basically involved an 18-month program of mental health consultation in urban and suburban regions of the county, and just briefly we did show some differences. We're able to show changes in children's behavior. There were some decreases in more externalizing kinds of behaviors like anger, aggression, anxiety and withdrawal, and significant improvements in children's pro-social behaviors in the classroom by the measures that we used. Okay.

SUJATA BANSAL: Okay. So, how many of you have heard the—I'm not sure it's called a fable--our little story, it's about an elephant and the blind man? Raise your hand if you've heard it already. Okay. So don't give it away please, and we're going to go through the short story so bear with us. Can the person who has elephant number one stand up and read, please?

UNIDENTIFIED SPEAKER: Once upon a time there were six (inaudible) native villagers told them, "Hey, there is an elephant in the village today." "I don't know what to do with my elephant (inaudible)." They decided, "Even though we would not able to see it, (inaudible)." All of them went for the elephant once and they (inaudible).

SUJATA BANSAL: Number two.

UNIDENTIFIED SPEAKER: "Hey, the elephant is like a tree," said the first man who touched his leg."

SUJATA BANSAL: Number three.

UNIDENTIFIED SPEAKER: "Oh no, it's like a rose," said the second man who touched (inaudible).

SUJATA BANSAL: Four.

UNIDENTIFIED SPEAKER: “Oh no, it’s like the sink,” said the third man who touched the trunk.

SUJATA BANSAL: Five.

UNIDENTIFIED SPEAKER: “It’s like a big hand fan,” said the fourth man who touched the ear of the elephant.

SUJATA BANSAL: Six.

UNIDENTIFIED SPEAKER: “It’s like a huge wall,” said the fifth man who the belly of the elephant.

SUJATA BANSAL: Seven.

UNIDENTIFIED SPEAKER: “It’s like a spear,” said the sixth man who touched the tusk of the elephant.

SUJATA BANSAL: Mm-hmm. Great. Thank you.

JANE BERNZWEIG: And eight.

UNIDENTIFIED SPEAKER: They began to argue about the elephant, and every one of them insisted that he was right. It looked like they were getting agitated. A wise man is passing and he saw this. He stopped and asked them, “What’s the matter?” They said, “We cannot agree to what the elephant is like.” Each one of them told what he thought the elephant was like. The wise man calmly explained to them, “All of you were right. The reason every one of you is telling it differently because each one of you touched the different part of the elephant. So actually, the elephant has all those parts that you each said. When you put each part together, you see something entirely different.

JANE BERNZWEIG: All right. Thank you. So, the reason we wanted to use this as a starting point to talk about our fourth program, Partners and Collaboration, is because as you can see through the elephant’s story, everybody comes in their own perspective and they’re limited in what they see, touch, hear or feel. And it’s not until we interact with somebody else and are open to their perspective and share our own perspective that we can see a more complete picture. So, Partners and Collaboration, which is our final strategy we’re going to talk about, is a training program where we pair a mental health consultant with a mentor teacher or ECE professional—and mentor teacher is basically an ECE professional has a high level of classroom experience, education and training themselves. And we pair these two folks together so that they could really train one another. The reason for this was that in my work with the mental health

consultants and with teachers, I was seeing that oftentimes the ECE folks were saying that they would like to receive more training, more education in mental health but they didn't have access to that, that their programs didn't teach them that. Meanwhile, we had mental health folks who are coming in as clinicians but don't necessarily have an ECE background, they maybe have not worked in group care, they haven't worked with very young kids. And so, each of them was lacking an essential component to be able to do the work and so instead of trying to send them all back to school, we thought what if we pair them with each other and have them train each other. And so, that's really the number one goal if this program was to have to have them train each other to integrate their experience and expertise so that when they go out into those classrooms they're able to provide more comprehensive services to those classrooms. And the classrooms benefit from having the perspective of two professionals. And we're hoping that this one trickles down so that eventually it reaches the children and that we see changes in their social and emotional behaviors. And it's been a successful program so far. It's young, it's a pilot program, and it's in its second year. But we've received a lot of positive attention and so we're hoping that it'll be training program for future use as well. (Inaudible).

SUJATA BANSAL: Okay.

JANE BERNZWEIG: Okay. So some of the results we've seen from this program—again, one thing that we were looking most closely was will pairing

these people of two different disciplines, two different professions and Deborah and (inaudible) have talked about how they come from very different areas. Will pairing them actually change their knowledge or their experience or their attitude about each other? So, remember we talked earlier about how it's a difficult partnership sometimes, and so will pairing them change those things? And we were happy to see that at the end of the project when we—so we did pre-interviews and post and there were changes in attitudes and changes in knowledge. One thing that we saw is that ECE providers were more likely to look at a child's home life, for example, in terms of interpreting their behaviors in school so they were more likely to make linkages to what's going on in the home is affecting this child and the child is acting that out in school. And that was a huge leap. The mental health providers, on the other hand, were much more likely to look at the classroom as a whole and not single out individual children, and come up with strategies that they could implement into the classroom that would affect all of the children and not just one child. So, one of the mental health consultant said that they were more likely—that they would be—that they would include more physical activities and circle time for kids who are fidgety, for example, whereas before, they might have focused just on an individual child.

So, these were some of the things that we were looking for and hoping to get. The Devereux Early Childhood Assessment, are people familiar with that tool?

UNIDENTIFIED SPEAKER: Mm-hmm.

SUJATA BANSAL: Yeah. Several not.

JANE BERNZWEIG: It's a tool that looks at the social, emotional class—environment of the classroom as a whole, and it does that by looking first at individual children and then putting all the individual children together and looking at the classroom profile. And we were happy to see changes in our pre-imposed (inaudible) as well after the peak project. So, one of our goals was that there—this would have a trickle-down effect, and we were able to see that with the kids.

SUJATA BANSAL: Okay. We wanted to do summary at this point. We're almost at the end. But we wanted to talk a little bit about some of the changes that we've seen. And I think most importantly, we have been able to see some changes in children's—decreases in children's challenging behavior and increases in positive behavior. And we've done that—we begun to do that by bridging the gap between the fields in mental health and ECE in our county in promoting standards of practice and doing that also through some very intensive efforts at professional development. And so, this is some of what we were hoping to present to you today and to show you today.

And we thought just one last sort of interactive part, if you're still with us, for just a few minutes. We wanted you to begin to talk in a small group. And so I'm thinking like just a couple of people just face each other over here and maybe on

that side, maybe even just two groups and talk about what, in your community, the community that you're in, what is—have you found to be the relationship between early care in education and mental health in those communities? And with that, what challenges have you met if you've tried to provide mental health—challenges to providing mental health to early care and education programs in your community? And then we'll come back together—like take maybe five minutes and we'll come back together and just talk about that a little bit. So, this half maybe if you're still with us. I hate to lose everybody.

JANE BERNZWEIG: Actually, if you want to just turn around and partner with somebody, that's fine too.

SUJATA BANSAL: That's even better. That's right.

JANE BERNZWEIG: That way we have such small numbers.

SUJATA BANSAL: Yeah. Good.

JANE BERNZWEIG: Instead of having them all get up.

SUJATA BANSAL: That's great. Okay. What's up?

UNIDENTIFIED SPEAKER: (Inaudible)

SUJATA BANSAL: Well, we could do it as a group. How about that? You want to do it as a big group?

UNIDENTIFIED SPEAKER: Yeah.

UNIDENTIFIED SPEAKER: Yes. We'll do it as a group.

SUJATA BANSAL: Okay. Yeah. So just take five minutes. That's five minutes.

JANE BERNZWEIG: No, let's just—

SUJATA BANSAL: Do it longer?

JANE BERNZWEIG: Yeah. Let's just do it right now as a large group. Together.

SUJATA BANSAL: Oh. Okay, because they were starting to split up. Let's do this. What do you think, do it as a large group?

UNIDENTIFIED SPEAKER: Large group together, right?

SUJATA BANSAL: Yeah.

UNIDENTIFIED SPEAKER: (Inaudible).

SUJATA BANSAL: Oh, well.

UNIDENTIFIED SPEAKER: I don’t know.

JANE BERNZWEIG: They already split up.

SUJATA BANSAL: Okay.

UNIDENTIFIED SPEAKER: (Inaudible)

SUJATA BANSAL: Yeah. So, let’s do this in large group together.

UNIDENTIFIED SPEAKER: Just let it go for a few minutes and then—

SUJATA BANSAL: Yeah.

JANE BERNZWEIG: Yeah. I mean, let it go just for a few seconds.

SUJATA BANSAL: Okay. Okay. Okay. Okay. So, I know we’re not giving you a lot of time, but why don’t we just wrap it up? And we’ll do it as a group now so whatever you have in your—

JANE BERNZWEIG: We’re almost out of time for discussion.

SUJATA BANSAL: We’re almost, because we want to try to get to a few final things before the session is completely over. Okay. And we want to encourage you, by the way, because even the way we ask it, it’s assuming that you have had relationship between ECE and mental health in your community. But if you haven’t, think about what might be the challenges so that those are the kinds of things we’re interested in hearing about. So, anybody want to offer up a tale of your community? Something about that you’ve tried doing and what’s worked, what hasn’t? Yes.

UNIDENTIFIED SPEAKER: Well, I’m from Washington State and we had some of the same challenges and the same interests. Long story short, lots of child care and early childhood provider saying this is a priority we really need help. We were fortunate to have a very large system of highly trained public health nurses as child care health consultants. And we have extended their training in social-emotional issues to do a lot of the same kinds of things upfront, problem solving, dealing with relationships, dealing with some of the kinds of things you showed in the videotape to start to get people that were already in the system and well-trained with all the background that would be needed to extend into challenging behaviors using their in-class training. And we trained them through the needed program to help promoting those relationships.

What we're finding now is in addition—plus, we're fortunate the new infant center for mental health at the University of Washington that was opened by Catherine Bernard. We recognized that that consultation is a lot on the front end of trying to do screening sort of into the child before it's a real problem and it has to be labeled as a mental health issue. But for those that do, then we have some actual current legislation that is in limbo right now as we speak, trying to see if we can get it through the legislature. That would fund some pilot projects to go to the next level to say when we identified children that we think actually have what may lead more mental health intervention, could we have some mental health consultation? And we're trying to do that bill do the talk and say at least if we create a two different—another entity that they should link and talk to each other because they're both intervening in chapter centers and families and in central homes. And one could be a resource because we're not going to be able—we know we won't be able to afford or have as many mental health consultant, so we could check and see, "Have you worked with your child care health consultant first? Have you done these other things?" Or if the child care health consultant gets to a point to say, "We need more involvement here." They would know there's a resource to go to the mental health list—consultation list and try and do that. So, it's really—I guess what I'm trying to say is we try to look that this is a continuum and recognize that with the volume of the problem, there'll never be enough money probably in the system. And we were talking here its hard enough

to get mental health services for older children to get people to (inaudible) for kids in period. But if we're talking zero to five, you really have some challenges.

JANE BERNZWEIG: Yeah.

SUJATA BANSAL: Yeah. That's an excellent point. Thank you. Other people having mental health programs or starting programs and thinking about programs? Anything you want (inaudible)? Yes.

UNIDENTIFIED SPEAKER: Well, we have a program around (inaudible) started mental health consultation in preschools. Some of the challenges that we're facing has to be getting the (inaudible) lots of child care centers that are waiting to have this, so we're not able to get out to everyone. So, that's been a challenge. And I think—

JANE BERNZWEIG: Are you the consultant?

UNIDENTIFIED SPEAKER: Yeah. Yeah.

JANE BERNZWEIG: Okay.

UNIDENTIFIED SPEAKER: But we are also starting to do—we found out that the pediatricians in our state and I don't know if this is nationally (inaudible). The

developmental screening process was done differently in different practices and some of them are just (inaudible).

JANE BERNZWEIG: Yeah. Right.

UNIDENTIFIED SPEAKER: It really wasn't anything that was—

JANE BERNZWEIG: Standardized.

UNIDENTIFIED SPEAKER: --standardized so we're trying to implement that into our state's standardized developmental screening. So, that's been a challenge. The other challenge I think is that our only intervention—well, they do a wonderful job of screening kids to see if they could walk, talk, but the mental health needs are not so good. So oftentimes, even though the parents are saying, "I'm happy with the challenges but my kids, they're not really going to take (inaudible) the programs." So some of the kids have been (inaudible).

SUJATA BANSAL: They fall between traps.

UNIDENTIFIED SPEAKER: Yes. Absolutely. So, those are some of the challenges.

SUJATA BANSAL: Interesting.

UNIDENTIFIED SPEAKER: Oh, and then the other thing is it's not—well, we have a system--children's mental health system up here that's very kind of developed in our state, and oftentimes doesn't really improve during the childhood because some of the eligibility requirements get into those programs is that the children need to have an STD diagnosis. And so, these children don't (inaudible) give them diagnosis so they end up not being able to fit under the guidelines of some of the programs.

SUJATA BANSAL: One more. Yes. Okay. Thank you.

UNIDENTIFIED SPEAKER: This is more about resource—potential resource to people who are doing mental health consultation. I'm Deborah Perry. I used to be at Georgetown University (inaudible) Nebraska (inaudible). In collaboration with our colleagues at Portland State University, we're actually developing right now a toolkit for evaluators who are trying to evaluate mental health consultation projects because I think one of the things that we felt that we need to do is kind of move this field forward. I think the work you guys are doing is really incredibly important in that area because what we've been basically saying is this is something that's really effective and we gather that the whole bunch of evaluation studies (inaudible) to see whether there were effects on children, families, programs, staff, and then publish a couple of things or method.

What we really think is that people don't have the tools they need to really, a, describe what mental health consultation is because it's not going to be a manualized something, that you're not used to do one and (inaudible) and it's not going to work out really well. But also, (inaudible). The parts of mental health consultation that are the most important are the relationship piece, as you guys said really nice things. And we don't have the tools to measure that. So, (inaudible) you're stuck with tools that don't measure what we really think is important but people who want us to be accountable for money that we're spending. And so, we're trying to (inaudible) developing this tool and we hope to have it out in the summer. And we would really appreciate people who are actually doing of this work, sharing some of their strategies so we can get that out to more people. I think this is a really work issue.

SUJATA BANSAL: Yeah.

UNIDENTIFIED SPEAKER: (Inaudible) on our Web site which is at (inaudible) but also Georgetown University, their Center for Child and Human Development. (Inaudible) the same thing. They have a Research and Training Center for Children, and also it's a team project (inaudible), so. It's really going to happen now.

SUJATA BANSAL: Great. Thank you. Okay. And the next slide, because we're getting close, this—what? Go ahead.

UNIDENTIFIED SPEAKER: After they're done (inaudible) you can come to office because we have done some fairly innovative work around (inaudible) have to evaluate that. There's no magic tool.

SUJATA BANSAL: Yeah.

UNIDENTIFIED SPEAKER: It's the first thing but you can (inaudible).

SUJATA BANSAL: Yeah. The challenges again that—this is just to reiterate what everybody said that we go around and around. This has to do with measurement and has to do with communicating amongst ourselves that the definition of mental health consultation is an issue in developing common language and standards and measurement. That mental health itself is, as someone pointed out just before, the whole issue of stigma and we want to diagnose people and all that kind of stuff, or give people a diagnosis. Varying needs or limitations in particular programs in terms of whether they even want a program and if they have the capacity to make the changes that we expect, its sustainability and recruitment and training of mental health providers. And we want them to be—to reflect the communities that they're working in and all those kinds of things that we talked about. So, the next steps.

JANE BERNZWEIG: Okay. So, what are some of the things we're doing to address them of those challenges? And we are going to continue funding agencies to provide the services because we know that if we stop funding them, the services are going to stop being provided. So, we're not doing the same partnership grant but we're changing it into a contract so we're going to contract with agencies to provide services, they still get funding to do it, and the training is much, much less intensive because now they've had four years of training hopefully. And then in terms of training, we are—we have different programs to training institute, to training coalition, to train both mental health and ECE providers around what are the needs of young children zero to five, how to address their social-emotional needs. We're trying to address the sustainability issue which is always hard and again, no magic answers to that either, but we're trying to look at identifying reimbursement strategies, looking at EPSDT funding and such. And Prop. 63, I know that's a California proposition which taxes our highest income earners in California and earmarks that money to provide mental health services. However, right now it's—again, remember we talked earlier about how our society is very treatment-based and so it's really looking at providing treatment mental health services. And so, our agency work—I with Dr. Deborah Vermont who's really a pioneer in this field as well. And she is advocating strongly to look at getting reimbursement for preventative consultation services. So, we have a couple of things going on on that end. We should try this, right? I like to end—oh yes, sorry. Go ahead.

UNIDENTIFIED SPEAKER: I (inaudible) takes time. I was just curious if you could a little bit about how you're actually using EPSDT (inaudible).

JANE BERNZWEIG: Yeah. It's really complicated in our—okay, but you—the short answer is that we're only using it for kids that have full scope Medical and they're the only ones—

UNIDENTIFIED SPEAKER: Medicaid.

JANE BERNZWEIG: Which is Medicaid. And they do have to have the diagnosis in order to get it. So, same Catch-22 that everybody else is experiencing. We're trying to get it so that it's—covers the preventative services. These are some resources for—or citations for different studies that we mentioned throughout the PowerPoint. And how many of you have been teachers in the past? A couple of hands. So, I like to end on sort of a positive note about the importance of the relationship between the teacher and the child. And I know that—and I'm preaching to the choir here but I think it's such a powerful story and so much of what we do in mental health consultation is about the relationship piece. So, it's—

SUJATA BANSAL: I'll hand this out, right?

JANE BERNZWEIG: Just wait till then.

SUJATA BANSAL: Okay.

JANE BERNZWEIG: Okay. So just bear with me through the story, but I think that at the end you will appreciate it. I know that we're about out of time so if you do have to go, that's fine. And we have copies of the story at the end if you'd like too. So it's called Mrs. Thompson and Ted. Has anyone heard the story already? Okay, good. And I used to be a preschool teacher so I like reading to people, so thanks for indulging me.

As she stood in front of her fifth grade class on the very first day of school, she told the children a lie. Like most teachers, she looked at her students and said that she loved them all the same, but that was impossible because there in the front row, slumped in his seat was a little boy name Teddy Stoddard. Mrs. Thompson had watched Teddy the year before and noticed that he didn't play well with other children. His clothes were messy and he constantly needed a bath, and Teddy could be unpleasant. It got to the point where Mrs. Thompson would actually take delight in marking his papers with the broad, red pen making bold exes and then putting a big F on the top of his papers.

At the school where Mrs. Thompson taught, she was required to review each child's past records and she put Teddy's off into last. However when she reviewed his file, she was in first surprised. Teddy's first grade teacher wrote,

“Teddy is a bright child with a ready laugh. He does his work neatly and has good manners. He’s a joy to be around.” His second grade teacher wrote, “Teddy’s an excellent student, well liked by his classmates, but he’s troubled because his mother has a terminal illness and I imagine life at home is a struggle.” His third grade teacher wrote, “His mother’s death has been hard on him. He tries to do his best but his father doesn’t show much interest and his home life will soon affect him if steps aren’t taken.” Teddy’s fourth grade teacher wrote, “Teddy’s withdrawn. He doesn’t show much interest in school. He doesn’t have many friends and he sometimes sleeps in class.”

By now, Mrs. Thompson realized the problem and she was ashamed of herself. She felt even worse when her students brought her Christmas presents wrapped in beautiful ribbons and bright paper except for Teddy’s. His present was clumsily wrapped in the heavy brown paper that he got from a grocery bag. Mrs. Thompson took pains to open it in the middle of the other presents. Some of the children started to laugh when she found a rhinestone bracelet with some of the stones missing and a bottle that was one-quarter full of perfume. But she stifled the children’s laughter when she exclaimed how pretty the bracelet was putting it on and dabbing some of the perfume on her wrist. Teddy Stoddard stayed after school that day just long enough to say, “Mrs. Thompson, today you smelled like my mom used to.” After the children left, she cried.

On that very day, she quit teaching, reading and writing and arithmetic. Instead, she began to teach children. Mrs. Thompson paid particular attention to Teddy. As she works with him, his mind seems to come alive. The more she encouraged him, the faster he responded. And by the end of the year, Teddy had become one of the smartest children in the class. And despite—excuse me. And despite her lie that she would love all the children the same, Teddy became one of the teacher's pets.

A year later, she found a note under her door from Teddy telling her she was the best teacher he ever had his whole life. Six years later, she got another note. He wrote he finished high school, third in his class, and she was the best teacher he had in his whole life. Four years later, another letter saying that while things had been tough at times, he stayed in school and would soon graduate from college with the highest of honors. He assured Mrs. Thompson that she was still the best and favorite teacher he's ever had. For more years and another letter, this time he explained after he got his bachelors, he decided to go further. The letter explained that she was still the best and favorite teacher he ever had but now his name was a little longer. The letter was signed Theodore F. Stoddard, MD.

The story doesn't end there. There was yet another letter that spring. Teddy met a girl and was going to be married. He explained that his father had died a couple of years ago and he was wondering if Mrs. Thompson might agree to sit in a place at the wedding that was usually reserved for the mother of the groom. Of

course, Mrs. Thompson did. And guess what? She wore that bracelet, the one with the rhinestones missing and she wore the perfume that Teddy remembered his mother wearing on their last Christmas together. They hugged each other and Dr. Stoddard whispered in Mrs. Thompson's ear, "Thank you, Mrs. Thompson, for believing in me. Thank you for making me feel important and showing me that I could make a difference. Mrs. Thompson, with tears in her eyes, whispered back. She said, "Teddy, you have it all wrong. You were the one who taught me that I could make a difference. I didn't know how to teach until I met you."

So, it's quite a sweet story. I think for—has a particular effect on me is having been a teacher and just realizing the importance that—I mean, I think that teachers get so marginalized in our society and they don't get the respect that they deserved, then teachers themselves start to believe that they're not that important. And I think this is such a powerful story and an emotional one that really highlights the kind of impact a teacher can have on a child and the difference that can make in a child's life. So, I like to kind of end on that uplifting although teary note. So that brings us to the end of our presentation. If you like a copy of that story we have copies right up here. Feel free to take some. It's great to hand out to teachers. I think they enjoy it quite a bit, so if you work with teachers. And we're around if you have questions. Thank you very much.

UNIDENTIFIED SPEAKER: Thank you both.

UNIDENTIFIED SPEAKER: (Inaudible) it reminds me of (inaudible) evaluation form because she (inaudible).