A System of Mental Health Service Delivery Models in Prekindergarten

Chair: Nicholas Ialongo
Discussants: Barbara Coatney, Barbara Ferguson Kamara
Presenters: Oscar A. Barbarin, Jonathan B. Kotch

- **ABLE: A Mental Health Screening Method for Preschool**
  Oscar A. Barbarin

- **Promoting Mental Health in Prekindergarten: The Child Care Health Consultation Model**
  Jonathan B. Kotch

Barbarin: Responding to early mental health concerns is an important part of Head Start, as many children come to schools with significant problems. Behavioral and emotional problems may interfere with learning, adjustment to school, and social development. Early intervention can impact prevention of larger, more serious difficulties. Adult disorders are often rooted in childhood experiences. Screening is important as 14 to 22 % of children have diagnosable disorders with potentially life-long consequences.

The most common concerns reported by teachers and parents are disobedience, aggression, impulsiveness, limited attention, difficulty getting along with other children, shyness, and excessive dependence. Head Start staff face dilemmas of determining the seriousness of the disorder and whether the problem is transient or stable. Staff is also concerned about letting problems go for too long, and deciding when and where to seek professional help.

Approaches to assessment differ in their assumptions, and there are also conceptual standards, including: (a) the negative standard as an absence of health; (b) the functional standard, the extent to which a person exhibits deficits in capacities or performance; (c) a comparative standard which compares a child and his or her symptoms to the mean of a norm-referenced group; (d) the impairment standard whereby symptoms presented do not represent a deficit, but impair a child's ability to perform roles and activities as other children; and (e) the disturbance standard, to what extent is the child's symptoms seen as upsetting or disturbing to others. It is important to distinguish between symptoms that are disturbances and those that are irritants.

Problems differ in presenting symptoms, and behaviors differ on the basis of age, gender, level of intelligence, social context, culture, ethnicity, and socialization experiences. Assessments of the level of psychopathology look at the intensity, frequency, duration, patterning, situation appropriateness and quality of the child's cognition, emotions, and behaviors.

There are also cautions in a diagnosis of disordered behavior. Teachers often want to avoid labeling or diagnosing a child. There should be as much emphasis on detecting competence and health as having a serious disorder. One cannot completely describe the child in terms of problems and must look at his or her competencies. If a child is overactive or impulsive, it is

problematic to classify him or her solely based on that label. It is possible to descriptively assign a number of labels and characteristics to a child without creating a master status for him or her.

Social context is critical in the conception of origins of disordered behavior. Families raise their children and prepare them for a particular context in which they are to grow up. Children aged 2 to 5 years are in the process of developing control over their bodies and their behavior, while cognitive changes are happening. Many skills do not develop at the same time or at the same rate for all children.

Risks at a societal level are also associated with higher prevalence and play a role in the evolution and presentation of child disorders. Certain inequities in our society create poverty, material hardship, malnutrition, community violence, quality of housing, abuse, neglect, and limited social resources.

There is indisputable need to provide mental health screening that is timely, efficient, inexpensive, and linked to an intervention. Early missteps in developing mental health screening processes were that the protocol was lengthy and too broad. Parents and teachers also tend to react to negative information, focusing on problems with their children. It is important to be modest in scope and pithy in expression.

The National Center for Early Development and Learning (NCEDL) study was conducted in California, Illinois, Kentucky, Ohio, Georgia and New York. In each state, 40 schools or centers were selected randomly and further stratified by teacher credentials. From these centers, one classroom was selected randomly, and four 4-year-olds were randomly selected per class. Because the study was random, it represented over 200,000 children in four states, and two regions of two states. About 47% of the sample were female, 87 % spoke English at home, 22 % spoke Spanish, and about 5 % spoke other languages.

The measures used in fall and spring were classroom observations, teacher questionnaires, and ratings of children by teachers. Child assessments included the Peabody Picture Vocabulary Test, Third edition (PPVT-III), the Oral and Written Language Scales (OWLS) Oral Expression, Woodcock-Johnson: Applied Problems in English and Spanish.

Of the study participants, 24 % were Latino, 35 % were White, and 27 % were African American. There was a good distribution of family income, with about 50 % of the sample living at 150 % of the poverty line, which is representative of those in public-sponsored preschool. About 25 % of mothers had completed high school, and 17 % of mothers had a bachelor's degree or higher.

In addition to the data from the NCEDL study, data was also collected in a Midwestern Head Start program. This group represented about two-thirds of all the children in the Head Start program in that setting, which was as close to universal screening as could be achieved, using Attention Behavior Language and Emotions (ABLE).

ABLE is a two-tiered rating system designed to provide early identification of school problems, targeting children between ages 3 to 5 years. It consists of a set of 10 questions that ask parents and teachers about persistent misbehavior, aggression, bad temper, fearfulness, sadness, poor language, impulsiveness, and having one's feelings easily hurt. The teacher asked the parent if there was something he or she had been concerned about within the past three months. The teacher asked about the duration, impairment, pervasiveness, comparative standard, generalizability of concern, unresponsiveness to intervention, exacerbation of problem, and the need for professional help.

In the development of the ABLE Level II, there was a 40-item scale including attention/ hyperactivity, aggression, opposition, language, emotion dysregulation. All of the ABLE scales rated by parents significantly correlated with teacher ratings on Teacher Child Rating Scale published by Hightower. Of those children identified as cases, 20 % were rated as being disobedient, about 18 % were rated as having language problems, 23 % had a bad temper, and a relatively small number had emotional problems. For the NCEDL data, if the child had two or more serious severity items, they were deemed as being a case and would complete the second part of the ABLE.

Part II is the application of the ABLE. A system of mental health care for early intervention and prevention includes universal screening of mental health concerns early in the school. It uses prevalence data to identify patterns of child problems and systemic concerns. The system provides follow up services at classroom, teacher, and child levels, and it links screening results to training and allocating and using mental health resources. Advantages of early universal screening are the planning of service delivery, allocating resources efficiently, becoming aware of possible problems in a class, using parental input, and having a metric for measuring problem severity. The first level of ABLE determines if there is a concern or not, and the second determines how serious is this concern.

Additionally, ABLE identifies problems related to attention, aggression, opposition, receptive and expressive language, and emotion disregulation. These areas were normed using the data from the NCEDL study. There were no statistically significant differences based on ethnicity on any of these measures, but there were gender differences.

Kotch: The Quality Enhancement Project (QEP) is a state-funded project funded by the North Carolina Division of Child Development, and the objective is to improve the quality of out-of-home child care for infants and toddlers in North Carolina through expanding and improving access to child care health consultation. Healthy Tomorrows is funded by the Maternal and Child Health Bureau of the Department of Health and Human Services, but it is a collaboration between Health and Human Services and the American Academy of Pediatrics.

A childcare health consultant is a child health professional who trains child care providers in health and safety, observes and assesses health and safety practices, evaluates training needs of parents and providers, consults on communicable diseases, provides resource and referral information, reviews policies, procedures and health records, provides knowledge for

management of children with special health needs, and helps parents and providers obtain needed health services, including mental health services.

Childcare health consultants do not perform hands-on child health care, nor do they supervise, regulate, or treat. The childcare center is the client and the childcare provider asks a consultant for help. The childcare health consultant is a generalist, and most of them are nurses who are supposed to be competent in all of these areas.

Studies show that 10 percent of American children will experience a social or emotional disorder that will cause some level of impairment in development learning or functioning in daily life. It has also been postulated that social and emotional disorders in preschool-aged children are the single most important risk factor for later antisocial behavior. Without treatment, disordered behavior is highly persistent, worsens with time, and creates 20 times the probability of a child being expelled from childcare.

In North Carolina, a survey of childcare providers asked about their top priority needs. Ten of the QEP childcare health consultants serving 20 counties across the state of North Carolina listed "challenging behaviors" as the top priority need for providers, and 40 others listed social and emotional health issues as one of seven health issues in need of support. A pilot of child care health consultants was conducted in three counties. The social and emotional health component was one of three separate activities funded. Each child care health consultant recruited 10 child care facilities in each of three counties, resulting in 1,100 children given passive parental consent to participate in this project.

The project offered the ABLE screening in the 30 child care centers. Among those 1,100 children, 439 received ABLE level one screenings. Children under 2 years if age were not screened. Some screenings of level one did not receive a level two follow-up, in part because some of the people were Spanish-speaking only. At that time there was not a level two assessment translated into Spanish. Not all of the forms were completely filled out. Of the 439 children who had a complete ABLE screening by teachers, two-thirds of them also had parental screenings.

The scores were almost identical to the NCEDL multistate study, and psychometrics held up well. A total of 115 cases passed level one, and 15 percent of these passed level two, requiring some intervention. Teachers tended to report more problems than parents. Childcare health consultants met with parents to debrief them. The parents of every one of the 4 percent of children from the total sample who required an intervention met privately with the childcare health consultant to develop a plan. None of the children required a referral to a mental health provider. Parents accepted the process, teachers were willing and able to screen after they were trained, and most parents were also willing to screen. There was not a single refusal among the parents either to participate in the screening or to meet with the childcare health consultant if it was indicated.

In other studies, Connecting the Dots takes the experience from the academic health departments and focuses on one county with a goal to maximize social and emotional growth and functioning in preschool children, minimize challenging behaviors, and prevent

expulsion. It is a model of a four-tiered approach to enhancing and promoting healthy social and emotional development in preschool-aged children starting with Level I.

For Level I, a curriculum for training childcare teachers was borrowed from the Center for the Social and Emotional Foundations of Early Learning at the University of Illinois in Champaign-Urbana. These six points are the themes of the curriculum modules adapted from that source – learning centers, organizing time, organizing space, developing rules, ignoring misbehavior, and positive attention.

At Level II is the ABLE screening. The childcare health consultants are involved at the second level of the screening test for children who may require a referral outside of the child care center. The first level of referral would be to that child's primary care provider, since it is not necessary to immediately refer children to a mental health provider. Level III is the referral to providers. It is the criteria for case status and triage based on the ABLE. Level IV is ultimately for a small group referral to mental health specialists. A network of local pediatric mental health specialists will be established for referral services for those few children who need this level of care. Expulsions due to challenging behaviors may be prevented by this multilevel approach.

For the evaluation process, records of staff participation and trainings are kept along with observations of changes in classroom structures and classroom teacher behaviors as a result of the Center for Social and Emotional Foundations of Early Learning training. Records will also be kept of the numbers of children screened, the screening results both early and later in the project period, records of the child care health consultants' follow-up with children, and referrals to primary care providers or mental health specialists.

An observation tool addresses the six curriculum modules in addition to a daily encounter form in North Carolina filled out online by all child care health consultants, resulting in an accurate measurement of the child care health consultant's daily activities.

Lindsey Allard: As a prekindergarten Head Start director, this presentation focuses on experiences of a program with mental health screening. A small screening instrument is given to parents when their children are registered. A team including nurse practitioner, mental health disabilities specialist, and the director go through the parent self report to see if the child has any health problems. After health problems are cleared, behavioral issues are examined so the child has a plan by the time school starts.

Teachers are given information about what they can do in the classroom to manage child behavior. If those strategies do not work, the behavioral specialists help the teacher to write a behavioral plan, and parents are given training on how to address different types of behavior. If all of these steps do not work, then the children are referred for special education services as a last resort.

Coatney: Mental health is the springboard of thinking, communication skills, learning, emotional growth, resilience, and self esteem. Recognizing mental health needs is a jumping-off point for school readiness and possibly the most important work that can be done to

prepare children for learning. Looking at the Head Start performance standards, 40 standards relate directly to mental health, so Head Start is taking a comprehensive approach looking at all of the areas affected by children's mental health. In terms of a service delivery model, of the young people who show signs of problem behavior, less than 10 percent receive services.

Teachers also report that challenging behavior affects their overall job satisfaction. In order to make classrooms happy places for children, teachers, and families, good tools and evidence-based practices are required to help people move along the continuum. Mental health is one of the most culturally laden fields in early childhood, and the way problems are communicated affect the mental health system, relating back to professional development and experience.

Audience discussion: The discussion emphasized the importance of not labeling the children, family, and social context within mental health, and emphasized that screening should focus on parent and teacher concerns about the child rather than using diagnosis to work around concerns labeling a child. Discussants agreed that it is best to talk about mental health in the context of social health, emotional health, social development, and mental development.

Audience members expressed concern over whether the ABLE is appropriate for children with languages other than English spoken in the home. Presenters responded that the ABLE focuses on receptive and expressive language whether the child is speaking Spanish or English. Some concerns were raised about teachers and children of different ethnicities, foreshadowing potential pitfalls in translation and consumption of information. Audience members expressed concern about a possible perception of labeling a child. Procedures are rooted within relationships.