

## A Model of Mental Health Service Delivery for At-Risk Preschoolers

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When young children demonstrate a mental health problem, the severity of the problem is often underestimated, or adults may assume the child will “grow out of it.” Adults may not recognize or acknowledge the problem, the child may have inadequate health insurance, or the family may not know where to go to receive quality mental health care (National Mental Health Association, 2000). Because of these barriers, preschool children have been historically underserved.

Despite the fact that preschoolers have been underserved, the prevalence of their mental health problems is substantial and similar to older children (Lavigne, Arend, Rosenbaum, Binns, & Christoffel, 1996). The number of young children experiencing emotional, behavioral, developmental, and medical problems is increasing (National Committee to Prevent Child Abuse, 1996). This appears to be particularly true of children in urban areas, with higher rates of poverty, unemployment, teenage pregnancy, crime, substance abuse, inadequate prenatal care, child abuse and neglect, and family disruption. The number of children under the age of five in foster care is on the rise (U.S. General Accounting Office, 1994). These children experience mental health difficulties related to the trauma of separation from biological parents, as well as the traumatic circumstances of abuse and neglect that led up to the removal from the home. Without prevention and intervention, they are at risk for developing ongoing mental health problems.

### A Preschool Mental Health Program Model

I have developed and direct a comprehensive mental health program to serve urban at-risk children ages three to six. Implemented through Family Connections in Orange, New Jersey, the program provides services to three collaborating preschools: Valley Settlement House in West Orange, Community Day Nursery in East Orange, and The Leaguers, Inc. in Newark. Through generous grant awards from the Success by 6 Initiative of The United Way of Essex and West Hudson and the Healthcare Foundation of New Jersey, this program offers services to over 1,000 preschoolers, their parents, and their teachers. This comprehensive preschool prevention program is unique in that it 1) is accessible to all, as services are integrated into one program that is delivered on-site, 2) provides services at a crucial and impressionable age when children face so many formative developmental tasks, 3) reaches parents when their children are still quite young, allowing for greater impact on positive child development, and 4) is community based at locations where families have already established relationships.

Providing services at a preschool within an Abbott district can greatly add to services to underprivileged children. An “Abbott District” is a public school district that receives state funds as a result of the Abbott vs. Burke case in which the court ordered the allocation of funds to ensure that the same amount of money was spent per pupil in poor districts compared to the average in New Jersey’s high performing districts. Another mandate required the State to offer high quality early childhood programs in these districts. Working in an Abbott district, the mental health consultant can benefit greatly from the resources and assistance from the Abbott-mandated Family Worker. The Family Worker provides social services to families, including counseling related to problems in the areas of housing, health, employment, etc., and also provides service training for parents, staff, and volunteers. The Family Worker can help in

developing relationships with teachers and parents, and help in identifying families' needs and the appropriate community resources to meet those needs.

Clearly explaining one's role as a mental health consultant and establishing a positive relationship with administrators, teachers, and parents is a vital foundation to conducting the work. Introduction to parents can be done at one of the school's parent workshops or "Parent Nights." Being visible during children's drop-off and pick-up times is an informal and productive method of establishing a relationship with parents. The consultant will also need to explain his or her role and function to teachers as well as outlining expectations from teachers in the collaborative relationship. Teachers can help the consultant identify children and families to receive services, execute referral forms, and complete classroom behavioral checklists, such as the Caregiver-Teacher Rating Scale (C-TRS) for children 1 ½ -5 (Achenbach & Rescorla, 2000). Class schedules and teachers' time preferences need to be considered in developing a schedule to render services. It is also extremely important to discuss confidentiality with preschool staff at the beginning of the collaborative relationship.

A mental health clinician on-site at preschools can provide individual play therapy, teacher consultation, developmental delay screening, a violence prevention curriculum, a personal safety and sexual abuse awareness curriculum, parent support, and crisis intervention.

### Individual Play Therapy

One of the major functions of the mental health consultant in the preschool setting is to provide individual play therapy to children referred by parents, teachers, or administrators. Play therapy in a preschool setting serves the same functions as in private practice, and can be set up in a similar manner. Psychologists working with young children are familiar with the benefits of play therapy. Through play, children engage in self-expression, which helps in developing and

defining the self, exploring the environment, gaining a sense of mastery, learning social skills, and fostering interpersonal relationships. Play helps to establish the relationship between the child and therapist. Through play, the child becomes self-disclosing, which helps the therapist learn about the child and make assessments without asking intrusive questions. Finally, play in therapy has a healing function. It helps the child to relieve tension and deal with defenses. Play provides the opportunity for corrective emotional experiences and permits the child to experiment with new behaviors in a safe environment.

The toys and materials of the play room are important and should be chosen for their therapeutic value. Common play therapy items include puppets, dolls of ethnic varieties, a school, a house, and figures, toys that suggest nurturance, such as kitchen equipment, play food, and baby bottles, and toys that facilitate communication, such as telephones and microphones. Materials that foster creativity and allow for construction help the child to gain a sense of accomplishment and mastery, which fosters self-esteem. Dramatic play materials encourage the child to act out fantasies or real life situations, to experiment with various roles, and provide another means of self-exploration and discovery.

Often children who are immediately referred for play therapy in the preschool setting are those who are challenging the teacher with aggressive behavior in the classroom. Educating teachers that shy, withdrawn, and uncommunicative children may benefit from play therapy may be necessary in identifying other children in need.

The child can also benefit from time with the therapist in the classroom. This serves to help the child in transferring skills learned in the individual sessions to real life situations as they arise in the classroom. The therapist can also serve as a model for the teacher regarding how to assist the child with the transfer of skills learned.

Mental health consultation in a setting with at-risk preschoolers requires experience and knowledge of the research in the area of child maltreatment. Research demonstrates the severity of negative effects in different areas. Children who have experienced maltreatment often have insecure attachments (Carlson, Barnett, Cicchetti, & Braunwald, 1989), poor peer relations (Dodge, Pettit, & Bates, 1994), negative or neutral affect regarding self-recognition (Schneider-Rosen & Cicchetti, 1984), aggression and avoidance with peers and adults (George & Main, 1979), and less cognitive and more aggressive play (Alessandri, 1991). Delays in language development and communication skills have also been noted (Culp, Watkin, Lawrence, Letts, Kelly, & Rice, 1991, and Crittenden, 1989). Finally, researchers indicated the importance of intervention in early years by demonstrating that these negative effects persist and often worsen, and that preschoolers are better adapters than older children (Crittenden, 1989). These long-term effects can be seen in later rejection by peers (Dodge, Pettit, & Bates, 1994), later academic performance and school adjustment problems (Eckenrode, Laird, & Doris, 1993), cognitive deficits, discipline problems (Dodge, et al., 1994), and problems in overall school adjustment (Cicchetti, Toth, & Hennessy, 1989).

### Consultation with Teachers

Another role of the mental health consultant is to provide consultation services to classroom teachers. Establishing a positive relationship with teachers in the beginning sets the groundwork for effective consultation services to take place. The relationship can also be fostered by requesting individual teachers' input about how the consultant can be helpful to them, perhaps during an informal coffee break with each teacher, and then following through with that information. Providing teachers with empathic understanding as well as useful information, strategies, and resources when they initially seek consultation helps to increase the likelihood that

they will seek out future consultation services. Respecting teachers' schedules is again very important.

Teachers may approach the clinician with questions regarding general classroom management, specific diagnoses, understanding a child's behavior, fostering language and literacy, and meeting children's emotional and behavioral needs in the classroom. Providing the teacher with a written summary regarding the discussion, as well as other resources for additional information, is useful and appreciated.

### Developmental Delay Screening

Screening preschoolers for potential developmental delays is another function of the mental health consultant within the preschool setting. Initial screening can be conducted informally through observations of children during the consultant's group work in the classroom (outlined below), or while consulting with teachers. Once a child has been identified as potentially having developmental delays, the parents are called in for a meeting with the mental health clinician, Family Worker, and classroom teacher. Often, this is the first time that a potential problem is being brought to the attention of the parents, and it would be helpful to have the staff member at the school who has the closest relationship with the parents be the one to call the parents in for the meeting.

During the initial meeting, specific concerns about the child's functioning are brought to the attention of the parents. The consultant can expect a wide range of emotional and behavioral reactions from the parents who may be hearing this information for the first time. This may range from denial that a potential problem exists to relief that help is available. Individual reactions also are affected by ethnic and cultural differences.

Before the screening can go any further, the consultant needs to obtain consent from the parents. The consultant must also obtain written consent to communicate with preschool staff, as well as to communicate with the local Board of Education. If the parent consents to further screening, a useful tool is the Developmental Profile II (Alpern, Boll, & Shearer, 2000). Teachers and parents can also be requested to complete the Caregiver-Teacher Rating Scale (C-TRS; Achenbach & Rescorla, 2000) and Child Behavior Checklist for ages 1 ½ to 5 (CBCL-parent form; Achenbach & Rescorla, 2000).

Once the screening is complete, if a decision is made to make a referral to the Child Study Team for an evaluation, the consultant can assist the family with drafting a letter of request for an evaluation and identifying the proper person to whom the letter should be sent. The mental health consultant can serve as a source of information and support to the families as they navigate the Child Study Team evaluation process. In addition, the consultant may assist in the process by supplying a summary report of the observations and assessments completed, as well as setting up a visit for the Child Study Team to observe the child in the preschool classroom.

#### Violence Prevention Curriculum

A comprehensive package of mental health services in the preschool setting can include prevention curricula in the classroom. Children can benefit greatly from a violence prevention curriculum. Studies have shown that exposure to violence is associated with an increase in aggression in children, whether the violence takes the form of witnessing community violence (Johnson, Catellier, Winsor, Dufort, Hunter, & Amaya-Jackson, 2002; Schuler & Nair, 2001), exposure to domestic violence (Rossman, Hughes, & Rosenberg, 2000), victimization in the form of physical abuse (Johnson et al., 2002; Dodge et al., 1994), the media (Villani, 2001), or bullying in the schools. Statistics regarding community violence are startling. One study revealed

that 60% of six year-old children living in the inner city in Baltimore had already witnessed someone being stabbed, shot, beaten, or threatened with a knife, with 7% witnessing someone being stabbed or shot (Schuler & Nair, 2001).

A violence prevention curriculum for ages four to six that has proven to be effective is “Second Step: A Violence Prevention Curriculum” (The Committee for Children, 1997). The curriculum consists of three modules: empathy, impulse control, and anger management. The lessons capture children’s attention with the use of large engaging photographs and adorable puppets. Lessons also include suggestions for classroom activities to reinforce the skills learned, and methods for transfer of training. Letters are also sent home to parents to inform them of the targeted skills so that they can reinforce these skills within the home. The curriculum consists of 26 lessons, which can be completed in six months at the rate of one lesson per week. The lesson is introduced during the first visit to the classroom in the week, and skills are reinforced with the second weekly visit.

Research has demonstrated the effectiveness of the curriculum with preschoolers. Children who participated in the program showed significantly higher violence prevention skills than children who had not participated. Specific areas of skill acquisition included listing cues associated with different feelings, devising solutions for problem solving when a peer has a desired object, verbal demonstration of a request, verbal demonstration regarding entering a group in a socially appropriate manner, and listing methods of calming down when angry (Moore & Beland, 1992).

Another study evaluating the effectiveness of “Second Step” involved 109 preschool children from a low-income urban area. Preschoolers demonstrated increased understanding of

social skills, a decrease in observed aggression, both physical and verbal, and less disruptive behavior (McMahon, Washburn, Felix, Yakin, & Childrey, 2000).

### Personal Safety Curriculum

A second prevention curriculum for group work in the classroom is “Talking about Touching: A Personal Safety Curriculum” (Committee for Children, 2001). Specific skills learned in the first module, “Personal Safety,” include car safety, traffic safety, fire safety, gun safety, what to do when lost, and asking a caregiver’s permission before accepting gifts, rides, or food. Skills learned in the second module, “Touching Safety,” include distinguishing between safe and unsafe touches, saying “no” to unwanted touches, learning “The Touching Rule,” and what to do if someone breaks “The Touching Rule.” (The “Touching Rule” is that a person older than the child should not touch the child’s private body parts except to help keep the child healthy and/or clean.)

This curriculum also includes suggestions for classroom activities to reinforce the skills learned and to transfer training. Letters are again sent home to parents to inform them of the targeted skills so that they can reinforce them at home. The curriculum consists of 15 lessons, which can be completed in four months by completing one lesson per week, using two visits to the classroom each week. Both curricula can be completed in a ten-month academic calendar.

### Parent Support

A comprehensive mental health package would be incomplete without a parent component. Parent support can be available on an informal, ongoing basis simply by being present during children’s drop-off and pick-up times. When parents are familiar with the mental health consultant and the consultant is visible, they are more likely to approach the consultant with their concerns and questions. Parent support can also be provided through workshops about

topics of interest in child development and mental health, or issues related to current events, such as helping children and families cope with terrorism and war. Parents who may be reluctant to seek mental health services may make use of a monthly parent advice column written for and distributed to all parents.

### Crisis Intervention

Mental health services within the preschool setting also include crisis intervention to parents, teachers, administrators, and children. This is a valued service in Newark and surrounding areas that have high rates of crime, substance abuse, poverty, child abuse and neglect, and unemployment. These issues create daily stressors in the lives of these families. Crisis intervention work requires knowledge and skills in the areas of child maltreatment, bereavement, serious physical illness, domestic violence, and community violence. The clinician must also be equipped to handle crises such as natural disasters and threats of terrorism. When the mental health clinician has a well-known presence within the school, parents, children, and teachers have access to crucial mental health services that may otherwise not be available due to the barriers previously mentioned.

According to the stress-buffering model (Cohen & Wills, 1985), the greater the network of social support, the better the chance that the negative effects of a stressful life event will be decreased. Kaniasty and Norris (1992) made the distinction between perceiving that the support exists and actually receiving the support. For victims of crime, perceived support consistently demonstrated buffering effects, whereas the effects of actually receiving the support were less noteworthy (Kaniasty & Norris, 1992). Utilization of the support of a mental health clinician, or even simply knowing that the support is available, can make a marked difference in an

individual's functioning. For this reason, crisis intervention continues to be an integral component of the preschool mental health program.

### Ethical Issues

Some ethical issues may arise in this model that may not be as common as in private practice. One issue that the mental health consultant will likely face deals with the loss of privacy. Since children are taken out of their classroom for individual play therapy, their classmates may be aware that they are receiving this service. Privacy can be maximized by communicating its importance to the classroom teacher and coming up with a plan to remove the child from the classroom in an inconspicuous manner. For example, the mental health clinician can stand outside of the classroom door, making eye contact with the teacher with a predetermined signal that it is that child's session time.

Another potential ethical issue concerns who the client is in the therapy. This is an issue because the child is not seen in isolation. The child is part of a school system with teachers and administrators who are involved in the child's life. Discussing this issue at the inception of the collaborative relationship will help minimize confusion regarding who is the consultant's client.

Another ethical issue concerns record keeping and access to records. It is imperative that all records are kept within a locked filing cabinet. It is important to discuss with preschool administration that a separate file will be kept on each child being seen for play therapy, and that these records are the property of the consultant or the consultant's agency. This file should contain all release and treatment authorization forms, as well as documented progress notes. The contents of these files, as well as information obtained from therapy sessions, is confidential according to State law. Information will be shared with staff on an as needed basis, as determined by the mental health consultant (only upon receipt of a signed release by the parent/guardian).

Confidentiality is a serious issue and needs to be discussed with administration, teachers, and parents at the beginning of treatment. It is highly likely that teachers and the mental health consultant will need to share information with each other for treatment collaboration. In order for the consultant to be able to do so, the consultant requires a written authorization to release information signed by the legal guardian. Its purpose and risks should be fully discussed with the legal guardian. The consultant also needs to address limits to confidentiality with the legal guardian, such as the consultant's obligation as a mandated reporter to report suspected abuse or neglect to child protective services. The consultant must also use discretion regarding what information is shared with preschool staff, as well as educate staff regarding the client's right to confidentiality.

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