Combining mental health treatment with education for preschool children with severe emotional and behavioral problems

By: Cathryne L. Schmitz and Alan Hilton

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Abstract:

With increasing poverty among families with young children, increasing violence in cities, and increasing stress in families, the needs of preschool children with emotional and behavioral problems are growing more complex. Although policy mandates services for these children, their needs are not adequately met. Well-integrated, collaborative, interdisciplinary, child- and family-centered programs are required. This article reviews the characteristics of preschool children with emotional and behavioral problems, discusses existing models of service delivery, and presents a collaborative model for services that integrates mental health treatment and education. Combined mental health and education service models can lead to improved outcomes for at-risk preschool children.

Keywords: behavioral problems | emotional problems | education | mental health services | preschool children

Article:

Until very recently preschool children with severe emotional and behavioral problems received little recognition in the professional literature, in teacher training, and in service provision. Although the population of preschool children with severe emotional and behavioral problems has grown since the early 1970s, there is considerable evidence that these children are underreferred for services (Swan, Purvis, & Wood, 1986; Walker, Bettes, & Ceci, 1984). Research about or even awareness of this group of children is inadequate (Hilton & Schmitz, 1988).

Early intervention linked to the child's home and community environment are indicated (Freeman & Dyer, 1993). Knitzer, Steinberg, and Fleisch (1990) pointed to the need for mental

health as well as education services for children with serious emotional or behavioral disorders, and Fox and McEvoy (1993) discussed the need for interventions that integrate family, school, and community services. This article reviews the characteristics of preschool children with emotional and behavioral problems, discusses existing models of service delivery, and presents a collaborative model for services that integrates mental health treatment and education.

Review of the Literature

Technology

The terms "emotionally and behaviorally disturbed," "emotionally and behaviorally disordered," and "seriously emotionally disturbed" are used interchangeably in the education and mental health literature (Institute of Medicine, 1989; Knitzer et al., 1990). The inference from the literature is that the terms "behaviorally disturbed" or "behaviorally disordered" are used in reference to youths who exhibit acting-out behaviors that fit criteria outlined in the DSM-IV as conduct or attention deficit disorders (American Psychiatric Association, 1994). The terms "emotional disturbances" or "emotional disorders," on the other hand, are applied to youths who exhibit symptoms related to depressive and anxiety disorders or posttraumatic stress disorder. The Individuals with Disabilities Education Act (IDEA) (P.L. 101-476, 1990) (Knitzer et al., 1990) defined serious emotional disturbance in terms of ability to learn, potential for interpersonal relationships, behavior, feelings, mood, and physical symptoms. The National Institute of Mental Health (Stroul & Friedman, 1986) describes serious emotional disturbance in terms of system involvement, DSM diagnosis, longevity of symptoms, and social functioning in various environments. The various terms are used interchangeably in this article to refer to children with emotional and behavioral problems severe enough to inhibit their ability to learn and to interfere with family, peer, and community relationships.

Extent of Need

Some researchers have estimated a significant population of children with severe emotional and behavioral problems: 11.8 percent of children have emotional disturbances, and 5 .0 percent exhibit severe symptoms (Stroul & Friedman, 1986). Although the identified population is increasing ("Improving Services," 1985), Knitzer (1982) estimated that only one-third of all youths with severe emotional disturbances receive the services they need. Site visits to programs for children and youths with emotional and behavioral problems revealed an inadequacy of services in the education system (Knitzer et al., 1990).

Resilience and Risk Indicators

Professionals point to the need for early intervention with families of high-risk children (Freeman & Dyer, 1993). Data indicate that behavior disorders are present in very young children (Maselli, Brown, & Veaco, 1984; Thomas & Chess, 1984). The professional literature shows that older children and adolescents with behavior disorders exhibited potential behavior problems at very young ages (Griffin, 1987; Spivack, Marcus, & Swift, 1986; Stevenson, Richman, & Graham, 1985). These early behaviors are strong indicators of later problems (Baenen, Glenwick, Stephens, Neuhaus, & Mowrey, 1986; Thomas & Chess, 1984).

Behavior problems in young children are predictive of later problems in social adjustment (Patterson, Capaldi, & Bank, 1991), and early oppositional behavior is related to conduct disorders later in childhood and adolescence (Kazdin, 1987). A study by Wehby, Dodge, Valente, and Conduct Disorders Prevention Research Group (1993) found that "children identified as high-risk at kindergarten demonstrate difficulties one year later" (p. 67). Because younger children respond more quickly to treatment, treatment through intensive preschool programs makes therapeutic and financial sense.

The individual, family, and environmental characteristics of children at risk vary widely (Freeman & Dyer, 1993). Practitioners are aware that the population of children and youths is not homogeneous. Children with emotional and behavioral problems exist along a continuum laid out in the education and mental health literature (Institute of Medicine, 1989; Knitzer et al., 1990; Stroul & Friedman, 1986). These children exhibit a range of behavioral, emotional, and neurological symptoms that interact with varying individual and family strengths and risks.

Studies of at-risk children receiving services, including child welfare, mental health, and education services (Anthony & Cohler, 1987; Schorr, 1989) and substance abuse and violence prevention services (Hawkins, Catalano, & Miller, 1992; Smith, Lizotte, Thornberry, & Krohn, 1995; Yoshikawa, 1994), identified a range of factors leading to risk and resilience among youths. These studies pointed out the importance of individualized assessment and holistic intervention. Individual, community, and circumstantial factors influence children's responses to stress (Anthony & Cohler, 1987; Garmezy, 1983).

Resilience Factors. Protective factors occur in children, their caregivers, and their environments; these factors interact with stressful events and risk factors to determine a child's level of vulnerability (Werner & Smith, 1982). Significant factors contributing to resilience and risk include parent functioning and education; child's age, developmental stage, gender, physical characteristics, intelligence, health, and temperament; and family characteristics such as family size, support, cohesiveness, perception of the child, discipline style, and stress (Rutter, 1983; Werner, 1987; Werner & Smith).

Children's self-esteem, achievement orientation, nurturing qualities, and sense of responsibility also affect their resilience (Werner & Smith, 1982). Children's problem-solving skills, coping strategies (Anthony, 1987; Cohler, 1987; Wahlsten, 1994; Werner, 1987; Werner & Smith, 1982), locus of control (Werner, 1987; Werner & Smith, 1982), and interpretation of events (Rutter, 1983) are additional factors. Finally, there is evidence that children who develop constructive coping strategies "have access to resourceful, positive, and stable persons in the environment" (Wahlsten, 1994, pp. 720-721).

Risk Factors. Studies indicate that the problems faced by disadvantaged preschoolers are growing increasingly complex (Edlefsen & Baird, 1994). The consequences to children of the economic changes occurring over the past 20 years are clear. Poverty is one of the major risk factors identified as increasing the vulnerability of children and families (Cohler, 1987; Werner, 1987; Werner & Smith, 1982). Children now constitute the poorest age group in the United

States (Kealing & Oakes, 1988). The poverty rate among children was 22.7 percent at the end of 1993 (Children's Defense Fund, 1995).

The most dramatic rise in poverty has been among families with young children. Twenty-five percent of children younger than six and 27 percent of children under three now live in poverty. Preschool children from low-income families experience more sociopsychological stressors and enter school with "fewer intellectual, social, and emotional school-readiness skills" than other children (Edlefsen & Baird, 1994, p. 567). Along with increasing poverty rates, children experience increasing rates of homelessness, parental substance abuse, and other major risk factors that contribute to family stress and negatively affect the socioemotional development of children (Children's Defense Fund, 1995).

Exploratory Study to Identify Traits of Children and Families Served

To understand the traits, characteristics, and needs of preschool children with emotional and behavioral problems, we used an action research plan (see Patton, 1990). Inquiry involved participant observation, conversational interview, and collaborative development. The authors, who have experience and expertise with intervention programs for preschool children with emotional or behavioral disorders, developed an understanding of the traits and characteristics common among preschool children with severe emotional or behavioral problems in collaboration with classroom and program social workers, counselors, and teachers specializing in day treatment with emotionally and behaviorally disturbed preschool children. On the basis of this collaborative process, we developed and refined an initial list of risk factors.

Sample Sites and Interviewees

Purposive sampling was used to select interview sites. Three sites, including the initial site, were chosen through a combination of theory-based and criterion sampling (Patton, 1990; Rubin & Babbie, 1993). Day treatment programs in two cities in two other geographic regions with demographics similar to the initial site were chosen: These cities had populations of 400,000 to 500,000 and surrounding areas with populations of 1 million to 2 million. Programs serving preschool-age children with severe, multiple emotional or behavioral disturbances were targeted to test the initial findings. One or two individuals from each site were interviewed.

Professionals having experience with young children with severe emotional or behavioral disturbances, familiarity with the characteristics common among preschool children with emotional or behavioral disorders, and knowledge and expertise in intensive preschool day treatment were chosen to review and discuss the criteria. Individuals were interviewed using a combination of the informal conversational and interview guide approaches (Patton, 1990; Rubin & Babbie, 1993). Through in-person and telephone interviews, interviewers shared the list of traits with the interviewees and then discussed how these traits fit with the professionals' experiences. On the basis of input from experts at the subsequent two sites, the list was modified. The final list was then shared with the first center for confirmation.

Traits Identified

The professionals we interviewed consistently reported that preschool children with severe emotional and behavioral problems exhibit many of the following traits:

- extremely aggressive or withdrawn behavior
- high need for control
- difficulty predicting the future
- difficulty with change, often even the slightest change
- lack of personal boundaries
- difficulty setting and accepting limits
- compulsive or impulsive behavior in work or play
- the tendency to elicit a negative reaction from others
- a wide discrepancy in developmental areas (for example, high in self-help but low in motor and socioemotional development)
- low ability to trust adults or to respond appropriately to classroom structure
- the need to test the environment for five or six months before making any noticeable changes
- cruelty to animals or other children
- lack of empathy or remorse.

Characteristics identified as exhibited by some children included immaturity for their age, involvement with multiple social services agencies, social and developmental disabilities, and an extremely stressful family life with few supports.

Many interviewers noted that not all children with severe behavior disorders had experienced traumatic family histories but that a significant proportion had. For children from troubled homes, the professionals described the typical experience as including several of the following elements:

- a long history of inconsistent parenting and a chaotic home life
- neglect
- physical and sexual abuse
- extreme emotional abuse
- several out-of-home placements
- a history of substance abuse by one or both parents
- family stress caused by poverty
- family stress caused by living with a child who has special problems.

Many of the children served by the professionals also had significant neurological impairments, communication disorders, or delays in motor development.

Existing Models of Service Delivery

The structure of traditional systems is inadequate to meet the needs of children with severe emotional and behavioral problems. The children and their families are diverse, and their needs are best met through collaborative service delivery that addresses socioemotional, economic,

safety, and educational factors. Successful programs are both child and family centered, are inclusive of families throughout the process, and balance the needs of the child and family.

There are currently two community-based approaches to providing services to children with severe emotional and behavioral disorders involving integrative programming: (1) classrooms in public schools that provide special education and regular education with added support and (2) day treatment programs provided by mental health or other social services facilities (Knitzer et al., 1990).

Public School Programs

IDEA (1990) requires the legal recognition of special-needs children from birth to six years of age by the education system and mandates services for children ages three and older. The mandates expand the population eligible for special education and related services. To fulfill these mandates, which call for young children with severe behavior disorders to receive appropriate services as close to their peers as possible, increased understanding of service needs and more collaboration among systems are required.

On the basis of reports from site visits, Knitzer and colleagues (1990) cited programmatic difficulties with many school-based programs for children with behavioral and emotional disabilities. They reported "low level academic efforts, simplistic behavioral interventions, inattention to transitions and continuities across grades, and a singular lack of access to mental health services" (p. 117). McEvoy, Davis, and Reichle (1993) also reported programmatic difficulties in serving the needs of young children with emotional or behavioral problems in school-based early childhood programs.

Although programs isolated from the school environment are ill advised for older children (Knitzer et al., 1990), preschool programs are frequently isolated both in schools and in private nonprofit facilities, thus lessening the stigma associated with isolation.

Self-contained classrooms can be effective, but their effectiveness can be diminished by administrative procedures that govern the size and composition of classes (Grosenick & Huntze, 1981). Large class size interferes with effective services. The addition of one extra child with a significant problem may make the classroom impossible to manage. Composition also has a major effect on the functioning of the class; too much diversity in age or level of functioning in a single class can disrupt the flow of the classroom (Stroul & Friedman, 1986).

Some school-based programs are comprehensive and rooted in basic research (Dougherty, Saxe, Cross, & Silverman, 1987; Stroul & Friedman, 1986). Guidelines are available on effective classroom programs that lead to a high rate of placement and maintenance in less-restrictive special education or regular education classrooms (Hilton & Schmitz, 1988). The most effective self-contained programs are multidisciplinary and provide direct services to the student. They involve the family in the change process, support children and families by providing access to a variety of community services, use varied intervention approaches in dealing with children, and include individualized educational programming (Baenen, Stephens, & Glenwick, 1986; Plenk 1978; Scruggs, Mastropieri, Cook, & Escobar, 1986; Soderman, 1985).

Day Treatment Programs

Many children receiving support services experience difficulties in traditional education settings. Day treatment can help keep children with serious emotional and behavioral disturbances in local schools or community mental health centers while allowing for continued contact with the family and the community at reduced emotional and financial cost.

Mental health day treatment programs offer nonresidential psychoeducational services incorporating education, counseling, and family intervention. Services are integrated, can be offered in a variety of settings, and frequently involve collaboration among service agencies. The most common settings for mental health day treatment programs are community mental health centers, public schools, special schools, social services agencies, and hospitals.

Programs have an average of eight to 10 students per classroom, with a ratio of one staff member to every two to four students. Most students stay in the program one year or longer. Studies indicate that the programs are effective in mediating behavioral difficulties and addressing academic and preacademic deficiencies (Stroul & Friedman, 1986). The typical cost of day treatment is $10,000 to $15,000 per year per student, whereas residential treatment frequently costs $30,000 to $50,000 per year per student (Stroul & Friedman, 1986).

Research has shown a high degree of effectiveness for day treatment programs (Friedman & Quick, 1983; Friedman, Quick, Palmer, & Mayo, 1982; Wood, Combs, Gunn, & Weller, 1975). Successful programs typically have the following features: a safe and nurturing environment, an individualized educational program that focuses on the child's needs, individualized mental health treatment plans, clearly stated disciplinary procedures, and strong links with the community and the family ("Improving Services," 1985). Other common features of successful day treatment programs include

- small classes
- family services, including family treatment, parent training, and individual counseling for parents
- case management of tangible needs
- family outreach with a psychoeducational focus to help parents understand both the developmental and special needs of their child (Freeman & Dyer, 1993)
- behavior modification for the child skills building and to improve interpersonal problem-solving and practical skills
- recreational art and music therapy to foster social and emotional development
- crisis intervention to provide support and assistance in the development of the family's problem-solving skills ("Improving Services," 1985; Stroul & Friedman, 1986).

Such programs result in positive changes in children's behavior, with most children subsequently entering the regular education system (Baenen, Stephens et al., 1986). Although interventions and treatment levels vary, nationally replicated models for the provision of day treatment services include behavior therapy, developmental therapy(Wood et al., 197 5), and environmental reeducation (Hobbs, 1982).

Collaborative Model

A number of studies have discussed the advantages of combining the resources and knowledge of education and mental health organizations (Edlefsen & Baird, 1994; Schorr, 1989). Day treatment provided through collaboration between educational and mental health services agencies offers the following advantages: flexibility of services, shared expenses, services that cost much less than residential treatment, and multifaceted treatment in the least-restrictive environment. Integrating service delivery allows the blending of funding streams from education and mental health to provide for enriched service delivery (Edlefsen & Baird, 1994). Additional benefits come from enhanced program development in local education agencies and mental health centers or appropriate child-serving counseling centers.

Collaborative programs function best when they are staffed by multidisciplinary teams, have low student-to-teacher ratios, and use the ecological approaches described in this article and in the literature (Baenen, Stephens, et al., 1986; Plenk, 1978; Soderman, 1985). Collaborative, multidisciplinary services expand the knowledge base, the ability to respond in a coordinated comprehensive fashion, and the depth of intervention (Melaville & Blank, 1991; Schmitz, 1995). A successful collaboration requires flexibility, creativity, facilitation, leadership, mutual respect, a commitment to quality services, and frequently a sense of humor.

Collaborations are, however, challenging because of role and time pressures, professional boundaries and competition, and personality clashes (Missouri Linc, 1992; Schmitz, 1995). Not only are professionals from the multiple disciplines trained with separate professional languages, creating communication barriers, but organizations and professions are set up with territorial boundaries designed to establish their expertise as primary. These boundaries take time, training, and commitment to overcome. Bureaucratic structures and regulations must also be overcome. Personalities also play a role in successful collaborations. The individuals involved must be flexible, committed, comfortable with ambiguity, respectful of others' expertise, and willing to share.

Key Components

The components of successful integrated programs include

- family-inclusive, child- and family-centered assessments and interventions
- classroom services with educational support and treatment for emotional or behavioral disorders
- assessment and treatment of communication and neurological disorders
- consistent disciplinary rules
- environments conducive to the building of positive relationships and trust
- collaborative, interdisciplinary service delivery
- case management
- culturally relevant and culturally sensitive services
- integration of the program into the local community and the child-serving community
- support in the transition to other programs with ongoing services when needed.

An ideal class in a successful collaborative program has approximately 12 children, three professional staff, paraprofessional staff, and professional support. The multidisciplinary classroom teams should include at least one teacher and one social worker and should foster an attitude of mutual respect, both personally and professionally. An expertise in early childhood development is imperative, as are support services addressing health, communication, and physical needs.

Although each child requires two individualized plans-education and mental health-service delivery must be integrated. Family members operate best as members of the team. They can become valuable allies in developing plans, participating in educational support, and assisting with transitions. Successful plans also require parent outreach, child development, recreation, and crisis intervention.

Staff Training

The provision of adequate services to children with serious emotional and behavioral disorders requires the availability of trained and qualified staff from a variety of arenas. These professionals must be able to work well on multidisciplinary teams. Staff members need skills in early childhood education and in mental health diagnosis and treatment. All staff members must be trained in working effectively with parents and families. In addition, staff must be trained in cultural issues so that communication and intervention are appropriate to the community context.

One of the first steps in interdisciplinary training involves the development of a common "jargon-free language" (McEvoy et al., 1993, p. 29). McEvoy and colleagues cited the importance of effective communication among team members, including professionals and parents, for effective assessment and intervention. An investment in comprehensive training that addresses specialized language, professional boundaries and knowledge bases, consensus building, and problem solving has benefits for team building and service delivery (Melaville & Blank, 1991; Schmitz, 1995).

Case Example

The Seattle Mental Health Institute (SMHI) preschool day treatment-special education program is an example of a collaborative program that has the necessary components of a successful program. Many young children with developmental disabilities and significant socioemotional developmental delays have been referred to the program by the Seattle public schools; most have entered regular education classrooms after participation in the program. The children served range from those with mild disorders (for example, socioemotional delays caused by psychoneurological impairment, trauma, or environmental factors) to children with severe emotional and behavioral disorders (for example, history of significant trauma and instability and significant neurological impairment).

Classroom services include preschool education, skills building, development of problem-solving skills, and treatment of socioemotional trauma. All classroom staff are trained in early childhood education and mental health treatment. The staff member with primary responsibility

for a child in the classroom also works with the child and family outside the class. As a result of the continuity, families feel a sense of commitment and support that is not present when they are in contact with many staff.

Parents are involved as partners throughout the process, assisting in assessment and treatment and participating in the classroom. Outreach to parents involves training in child development and management and family counseling. Case management services help families meet basic needs and acquire additional resources. Staff support is available to help the child's transition into regular classrooms or other programs. The collaborative relationships formed while the child is in the program help establish an ongoing safety net for the child and family.

The preschool program has been integrated into the community through SMHI's Children's Center, thereby fostering a community perception of the program as a preschool center rather than a mental health facility. This perception is important in building a bridge to an ethnically and economically diverse community. The agency has worked to diversify the staff to reflect the composition of the community of families served. The agency is also very active in training staff on cultural issues and needs, including the mental health concerns of diverse ethnic communities.

The program records of staff of the Seattle program who were interviewed for this study indicate success in helping children and families achieve more positive outcomes and improved educational successes and maintain children in the family setting. Of the 36 children served from Seattle Public Schools during the years 1987 to 1989, 53 percent entered regular education programs or less-restrictive special education programs for children with developmental delays. An additional 20 percent entered transition kindergarten classes with fewer emotional and behavioral difficulties. Only one child was placed in a residential program, and staff questioned the appropriateness of that placement. Twenty-seven of the children continued to require intensive day treatment programs or self-contained special education classrooms. These findings are consistent with early, limited indications from other programs that preschool children with severe emotional and behavioral disorders, after exiting intensive and effective intervention programs, can enter regular classrooms (Swan et al., 1986).

Role of Social Work in Collaborative Programs

Social workers must be part of multidisciplinary classroom teams. Because team members cross-train each other, teaching, social work, and counseling staff have overlapping roles in the class, thus allowing for continuity among the educational, support, and counseling needs of the students. Although the teacher takes the lead in developing learning plans, the social worker takes the lead in developing plans to meet the emotional needs of the children. Teachers and social workers may also blend their expertise in reaching out to and working with families, but social workers, in coordination with other counseling staff, frequently have primary responsibility for individual, family, and group treatment and support, skills building, and case management services. The nature of the children's difficulties and the programmatic needs place social workers in a pivotal role (Edlefsen & Baird, 1994) because of their professional expertise in service delivery and systems change.

As program planners, social workers are vital in developing multidisciplinary, holistic, collaborative programs. The flexibility of the social work professionals and their understanding of assessment and intervention set the tone for an inclusive model. Social workers are integral players in the implementation and ongoing functioning of successful programs.

Conclusion

Young children with severe emotional and behavioral problems are in great need of services. Preschool day treatment programs that meet the socioemotional and educational needs of young children and their families through integrated service delivery are the most effective and cost-efficient mechanism for addressing the needs of this special group. Programs must integrate education and mental health treatment; work with families in building on strengths; be collaborative in nature; be based on a solid knowledge of cultural issues; and provide continuity across services, staff, and time.

This article has discussed a general framework; program specifics must be developed by local service providers on the basis of local needs and service patterns. As a profession that trains practitioners in both service delivery and systems change, social work is the ideal field to take the lead in developing collaborative programs serving the needs of high-risk preschool children and their families. Social workers can facilitate relationship building among multiple disciplines, help design and implement collaborative service delivery, train multidisciplinary teams, and take the lead in evaluating programs.

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