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## Influencing Young Children's Mental Health: Designing Effective Program Approaches

The increasing proportion of Head Start children in need of mental health services led Piotrkowski, Collins, Knitzer & Robinson (1994) to call for a "paradigm shift" in the way that Head Start programs address children's mental health needs. Effective mental health services, they argued, should not rely on traditional problem-focused services provided by clinicians outside of the program context. Instead, services should take a holistic approach, emphasizing prevention, family involvement, and integration of mental health services with other Head Start components. However, despite changes in Head Start performance standards, mental health services vary widely across Head Start programs, with many programs continuing to take a traditional, narrow view of mental health (Yoshikawa & Knitzer, 1997). Consultants are often used in limited ways (e.g., only for time-limited observations and assessments), and are not considered a core part of service delivery to all families.

To facilitate effective services, Yoshikawa and Knitzer (1997) urge programs to involve mental health professionals on-site and in an expanded role in program delivery, especially by providing "program-level" consultation (for example, training and meeting with staff; Cohen & Kaufmann, 2000). However, there has been little research to document the benefits of this more integrated model. The present study was designed to address this gap, and posed three primary research questions:

1. What is the nature of mental health consultation in Head Start settings? (Have programs developed more integrated, holistic models of early childhood mental health consultation?)

2. What is the evidence that these more integrated models of consultation are effective?
3. What can Head Start program managers do to help facilitate more effective mental health consultation?

## METHODOLOGY

79 Head Start programs agreed to participate in a mail survey. Programs were selected from a stratified random sample representative of core Head Start programs<sup>1</sup>. 1265 surveys were sent to a random sample of 12-18 staff in each program, including a variety of staff positions. 803 surveys were returned (63%).

### *Survey Instrument Domains*

The survey collected data about five areas as listed here. Additionally, program directors completed an addendum that provided descriptive information (such as total children, sites, consultant characteristics, program budget, etc.).

1. **Mental Health Consultant (MHC) Activities:** 10 questions asked about the frequency with which consultant(s) engaged in different activities, rated from 1 (rarely/never) to 5 (weekly or more).
2. **Mental Health Consultant (MHC) Characteristics:** Staff rated the MHC's quality of relationships with staff and parents, cultural competence, and level of integration into the overall Head Start program.
3. **Mental Health Leadership:** Staff rated the quality of leadership specific to supporting children's mental health, and the level of training and support provided for staff.
4. **Staff Practices:** These questions asked staff the extent to which their program's mental health services were: inclusive, strengths-oriented, prevention-focused, family-centered, culturally competent, and integrated across program components.
5. **Effectiveness:** Staff rated the extent to which their program's mental health services were effective in supporting or preventing specific kinds

<sup>1</sup> Migrant, tribal, and Early Head Start programs were excluded.

of child behavior, as well as the effectiveness of the service delivery processes.

## RESULTS

The survey was completed in February 2003, and analyses are still ongoing. Preliminary results, organized according to the primary research questions, suggest the following:

*#1: Are Head Start programs providing integrated, holistic mental health services?*

As can be seen in Table 1, there remains considerable variability in the level of consultation that programs provide, and in the nature of consultant services. However, compared to the survey results of Piotrkowski, et al. (1994), more programs appear to have consultants who are engaged in activities beyond individual, child-focused therapy. Our results show that a number of programs (n=47, or 60%) use program-level strategies (e.g., formal and informal training of teachers) at least every other month.

In other ways, however, change is less apparent, at least at the structural level. For example, Piotrkowski and colleagues reported that 19% of their sample (15 programs) had mental health specialists on staff, which is similar to our finding of 21% (15 programs).

*#2: What is the evidence that these more integrated models of consultation are effective?*

Programs were grouped into "high integration" and "low integration" categories, based on average staff ratings. Analyses were conducted comparing these groups (see Table 2). As can be seen, compared to low-integration programs, more integrated models were generally perceived as being more effective. Staff from these programs reported higher levels of "promising practices", and perceive their program's services to be more effective.

*#3: What can Head Start program managers do to help facilitate more effective models of consultation?*

As a first step to address this question, we examined the role of mental health leadership. Programs with strong leadership in the area of mental health appeared to structure mental health services differently,

**Table 1. Characteristics of Mental Health Consultation**

Low-Implementing Programs	High-Implementing Programs
<ul style="list-style-type: none"> <li>• 57% (31) of programs report fewer than 1 hour of consultation per child, per year</li> <li>• 37% (20) report fewer than ½ hour per child</li> </ul>	<ul style="list-style-type: none"> <li>• 26% (13) of programs report more than 2 hours of consultation per child</li> </ul>
<ul style="list-style-type: none"> <li>• 71% (35) of programs report less than one half-time mental health consultant</li> </ul>	<ul style="list-style-type: none"> <li>• 29% (14) of programs report one half time mental health consultant or more</li> <li>• 16% (8) report one full time consultant or more</li> </ul>
<ul style="list-style-type: none"> <li>• 37% (30) of programs report consultants who provide child-focused services less than 1-2 times per year</li> </ul>	<ul style="list-style-type: none"> <li>• 11% (9) of programs report consultants who provide child-focused services at least monthly</li> </ul>
<ul style="list-style-type: none"> <li>• 40% (33) of programs report consultants who provide program-level consultation less than 1-2 times per year</li> </ul>	<ul style="list-style-type: none"> <li>• 7% (6) of programs report consultants who provide program level consultation at least monthly</li> </ul>
<ul style="list-style-type: none"> <li>• 79% (56) of programs rely on contracted mental health consultants</li> </ul>	<ul style="list-style-type: none"> <li>• 21% (15) of programs report that they have at least one mental health consultant who is a salaried staff member of the program</li> </ul>
<ul style="list-style-type: none"> <li>• 46% (31) have less than one ½ time mental health services coordinator</li> </ul>	<ul style="list-style-type: none"> <li>• 54% (36) have more than a half time mental health services coordinator</li> <li>• 18% (12) have a full time mental health services coordinator</li> </ul>

compared to those with weaker-rated leadership. For example, programs with stronger leadership spent a higher percentage of their Head Start budgets in the mental health area (3.8% vs. 3.0%). Programs with stronger mental health leadership also had consultants who were more integrated into program functioning, and who provided a wider variety of services. In regression analyses, leadership accounted for significant additional variance in the frequency of both program-focused and child-focused consultant activities, even after controlling for the total amount of consultation time provided.

## DISCUSSION

This survey represents one of the few large-scale attempts to gather data about the kinds of mental health consultation being implemented in Head Start programs, and about the effectiveness of those services from the perspective of Head Start teachers,

administrators, and others. Data suggest that although some Head Start programs are beginning to change their approaches and adopt more holistic models, a large number continue to rely on consultants who provide relatively limited levels of child-focused services. Results also suggest that developing integrated models is a worthwhile venture, even for programs with limited resources. Analysis of informative qualitative data describing program training activity, staff development strategies, and creative approaches to leveraging mental health resources was also included in the presentation.

## REFERENCES

Cohen, E., & Kaufmann, R. (2000). *Early childhood mental health consultation*. Washington, D.C.: Center for Mental Health Services, SAMHSA, US Dept. of HHS. (Available from Georgetown University Child Development Center.)

**Table 2. Mental Health Program Structure, MHC Characteristics, Staff Practices, and Outcomes for High vs. Low Integration Programs.**

	Low Integration Programs	High Integration Programs*
<b>Mental Health Program Structure</b>		
Hours consultation per child	1.57 hrs	1.95 hrs
% of budget spent on mental health component	3.6%	3.3%
Frequency of program level consultation (1=rarely/never; 2=1-2x/year; 3=every other month; 4=monthly; 5=weekly or more)	2.2	3.1***
Frequency of child-focused consultation (1=rarely/never; 2=1-2x/year; 3=every other month; 4=monthly; 5=weekly or more)	2.3	3.0***
% with Salaried MHC	16%	24%**
% with written MH mission statement	78%	85%*
Total hours of MH consulting	810	1150 hrs**
% with other sources of funding for MH services (beyond core Head Start funding)	27%	37%**
% with in-kind commitments for MH services	62%	63%
% with more than 25% of children needing MH services	16%	16%
<b>MHC Characteristics</b> <b>1=strongly disagree; 2=somewhat disagree; 3=somewhat agree;</b> <b>4=strongly agree</b>		
Culturally Competent	2.7	3.5***
Positive Relationships with Parents	2.5	3.4***
Positive Relationships with Staff	3.2	3.9***
Available when Needed	2.8	3.6***

Piotrkowski, C. S., Collins, R. C., Knitzer, J., & Robinson, R. (1994). Strengthening mental health services in Head Start: A challenge for the 1990s. *American Psychologist, 49*(2), 133-139.

Yoshikawa, H., & Knitzer, J. (1997). *Lessons from the field: Head Start mental health strategies to meet changing needs*. New York: National Center for Children in Poverty and the American Orthopsychiatric Association.

Table 2 continued

<b>Staff Practices</b> 1=strongly disagree; 2=somewhat disagree; 3=somewhat agree; 4=strongly agree	<b>Low Integration Programs</b>	<b>High Integration Programs*</b>
Inclusive	2.8	2.7
Difficult to serve behaviorally challenged children	1.9	2.2
Prevention orientation	2.3	2.7**
Strengths Orientation	3.2	3.6***
Parent Involvement	3.3	3.6***
Cultural Competency	3.2	3.5***
<b>Child Behavior Outcomes</b> 1=hasn't helped; 2=helped a little; 3=helped somewhat; 4=helped a lot		
Improve positive behavior	2.9	3.5***
Reduce internalizing behavior	2.6	3.2***
Reduce externalizing behavior	2.7	3.3***
<b>General Program Outcomes</b> 1=strongly disagree; 2=somewhat disagree; 3=somewhat agree; 4=strongly agree		
Classroom transitions are smoother	2.8	3.5***
MH services need improvement	3.1	2.5***
Staff feel supported	2.8	3.3***
Staff practices are improved	3.2	3.6***
<b>Other Outcomes</b>		
Time between referral and assessment 1=1 week; 2=1-2 wks; 3=2-4 wks; 4=1-2 months; 5=> 2 months	3.0	2.5***
% of children who received group screening 1=<5%; 2=6-25%; 3=26-50%; 4=51=75%; 5=>75%	4.7	4.8

\*Statistical tests compared high vs. low integration programs using ANOVA for continuous dependent variables and Chi-squared for categorical dependent variables.

\*p<.05

\*\*p<.01

\*\*\*p<.001