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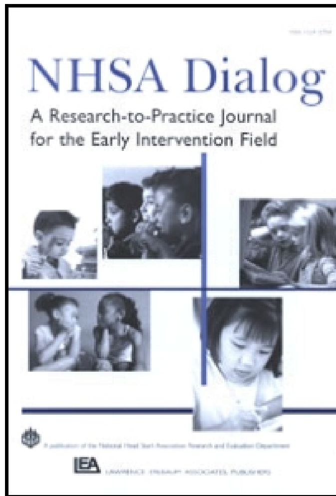

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Epidemiology and Assessment of Mental Health in Poverty Populations: Implications for Head Start

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Epidemiology and Assessment of Mental Health in Poverty Populations: Implications for Head Start

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PRESENTER:
Esther Sinclair

I will speak about the scope of UCLA's involvement with the mental health component in Head Start and about the two areas of need that I consider to be the most pressing on mental health programs: (a) the attitudes of the staff and (b) communication between the agency and the families.

For the past 16 years, I have been the point person and coordinator of an unofficial university partnership between the UCLA Department of Child Psychiatry and a large urban Head Start program in Los Angeles. This program has existed for 16 years without grant support because it has been useful to the Head Start agency. We have acted as the mental health and special needs consultant to this agency of just under 1,000 children in 60 different classrooms at 17 sites. Over the course of the years, the scope of our work has changed. We have learned much and made many mistakes. We tried to comply with guidelines presented by the grantees and the federal government, and therefore we changed our practices as appropriate.

UCLA is an interdisciplinary training setting in child psychiatry, so we have trainees that represent child psychiatry, clinical psychology, edu-

cational psychology, speech and language, social work, occupational therapy, physical therapy, and pediatrics. All of these disciplines are involved in Head Start.

I am thrilled to hear this panel discuss the importance of onsite consultants because that is what we have been doing for 16 years. Years ago, it was not that popular to go into the community and work in local programs, and we had to work hard to get students who wanted to have the Head Start experience. Now, the placement is so popular that we can select trainees for our program who are bilingual and bicultural. This is important because the Head Start agency with which we are working has 94% Latino families.

We have provided teacher training and teacher education. We have consulted regarding classroom and behavioral intervention programs. We have done screening and classroom observation. This relationship took years to develop. There are many problems with agency/university partnerships. Many Head Start agencies are afraid that the university will take them over, that we have our own research agenda, and that we are going to ask their teachers to fill out forms to collect data useful for our publications, but worthless to the agency.

It took many years to develop the trust necessary to do research within this agency. The Rodney King decision in Los Angeles occurred at the Cinqo De Mayo holiday. There was no school in celebration of Cinqo De Mayo. The agency director called me at home to say she was worried about what they would find when the children came back to school on Monday. She asked for my help. Because we are dealing with UCLA and we have so many wonderful professionals there, I was able to call on a team of people who had just came back from Bosnia where they had been dealing with posttraumatic stress disorder due to community violence. We asked them what to expect in Head Start when the children returned. I asked them to work with parents to provide a forum to talk about the violence.

Another time, the director called during the Christmas holidays to say that one of the children was killed in a traffic accident. The teachers were overcome with grief. They did not know how to tell the children or help the parents. We put together story and flannel board activities for the children and a presentation for parents on how to talk to a young child about death and dying. It takes a long time to develop that kind of program. We have moved away from a service delivery system that only looks to identify and refer children and moved to an intervention system that enhances the mental health of everyone involved in the Head Start community, including the staff.

These are the accomplishments we are proud of. However, we face problems pertaining to teacher attitudes. We need to increase the knowl-

edge, awareness, and interpersonal skills of staff members. Over the years, we have tried many different classroom observation techniques. We have moved from descriptive techniques to more clinical interpretations of what children are doing. In an attempt to identify children that are at risk for behavior disorders, we have utilized Feil's Early Screening Project (ESP), a very effective method. We have gone to structured screening tools, and we found that we have to make a major educational push with staff to explain the terminology of target behaviors that we feel to be symptomatic of future at-risk status. To do this, we meet with the staff once a week. In this particular Head Start program, it is not an all-day program; it is a morning and an afternoon program. We meet with the morning teachers when they have free time in the afternoon, and we meet with the afternoon teachers when they have their free time in the morning. We talk to the teachers about these target behaviors. They are quick to identify the externalizing, acting-out children. The children who are withdrawn, noncommunicative, and isolated are another story altogether. We try to explain the importance of identification, and then we discuss what we are going to do to address the problem. We develop strategies to work more effectively with children in the classroom who are exhibiting these behaviors. It is disheartening to visit centers month after month and see the same thing going on where none of these interventions has been effective. We are trying hard to have consistent follow-up so that we can make a difference.

I can only speak from my experience with one agency, but I think that this agency reflects what is going on in other agencies throughout our state and country. There is a huge disparity between the teachers and assistant teachers in the classroom. The assistant teachers depend upon the teachers for evaluations which lead to salary raises and continued employment. As a result, the assistant teachers must do what the teachers tell them, which they often resent.

In this agency, it is the assistant teachers who, by and large, are Spanish speaking. Because they are Spanish-speaking, they control the flow of information between the family and the agency. Creating consistency in the classroom is difficult. Getting the teachers and assistant teachers to agree on what to say about the child in order to provide the consistency in the classroom that is necessary for change is a big problem. Through my involvement in Head Start, the staff have taught me enough Spanish to be able to communicate with children and parents. How can we make an effective change with children when the parents feel that the professionals involved are not even together on what is being said?

Why do we have this problem? There is an extraordinary amount of resistance on the part of staff to identify children. Most of the Head Start teachers that I meet are incredibly committed to their children. They want

to do what is best. However, they do not believe that identification and referral is what is best and, therefore, do not do it. Many of them have had their own experiences with special education; some were in special education themselves. Perhaps their own children, children they are raising, or children whom they love have been in special education or have been identified as having mental health problems in the school. They see special education as a road to nowhere.

This is an enabling opportunity. We can present many options to help children. However, as long as the staff feels that early identification and referral is disabling rather than enabling, they will not participate in the identification process in a meaningful way. This is why an entire programmatic year goes by and we hear in May, 3 weeks before the program is over, that a particular child has still never said anything out loud. Why did we not hear about this child before? We have to work on attitudes.

This also relates to why we have such an overidentification or preponderance of speech and language problems while we do not have referrals for mental health issues. That is because there is far less stigma attached to speech and language difficulties. In the past few years, our state began requiring public schools to provide speech and language evaluations. Where we once had a true mental health interdisciplinary team that met every week at Head Start, now we have become very fractionalized. The Head Start administrators and coordinators will refer speech and language issues to the school district, mental health issues to UCLA, and disabilities and special needs somewhere else. This fractionalization has been counterproductive for communication between providers. Our point of view in the agency has been that regardless of why a child is referred to our team, we do a comprehensive look at all domains of functioning. When that is done, areas of concern unrelated to the reason for referral are discovered. However, with this fragmentation of services, the right hand does not know what the left hand is doing. There are people out there evaluating speech and language needs who do not know what the rest of us are doing, and that has been a problem.

Jane Knitzer talked about an opportunity for mental health consultants to get together to share visions of the present and the future. That is very important. The mental health coordinators in the agencies get together often, but the mental health consultants never do. In 16 years, I was never once invited by the Head Start grantee to meet with other mental health consultants to discuss how we are trying to help the agencies comply with regulations. We need more leadership from the grantee. Every year the mental health coordinator spends an entire summer trying to figure out how best to comply with the regulations. The grantee could provide more leadership rather than just saying, "This is good. This is not." We need that leadership.

The teachers' attitudes, of course, infiltrate to the parents. We know that many teachers are reluctant to discuss these issues with parents. Parents are reluctant to discuss these issues with staff members. We need to have a more systematic way of collecting information. Also, there is a concern about location of documentation. The information, which does exist in Head Start, is not found in the children's files at the centers where the people who work with the children need to know what is going on. When the children are enrolled in programs, it is the health coordinators that often do the enrollment and ask the parents to fill out forms. In a small research study we did, we found that in our agency of almost 1,000 children, 25% were prenatally drug exposed. That information was not available at the time of enrollment because it was not asked for. This usually trickles down anecdotally, as problems arise. The staff talk to the parents and the parents then feel a comfort and trust level great enough to share information that they never would have given at the time of enrollment.

We need to help parents see that these programs are not about exclusion and labeling, but about inclusion. Every year we have a transition program where we try to encourage parents to go to the public schools and share the information from Head Start. We have found that of those children for whom we recommend special education, only one in five parents ever tells the public school because they feel the stigma. It is a new school, a new beginning. The parents do not want to bias people's opinions about their child. Also, we know that kindergarten teachers rarely refer children to special education because they do not have the privilege of understanding the chronicity of a problem. So, they do not want to upset the parents. They want to see if they can have a chance to help. That is why years go by without addressing problems. We need to work on teacher attitudes and improving communication between the agency and the parents. Teacher attitudes and poor communication are two looming problems for a mental health agenda.

Head Start and Mental Health: An Argument for Early Screening and Intervention

Edward G. Feil *

In contrast to many preschool providers, Head Start, as a general rule, focuses upon the mental health of its families. Social development, including parenting practices and social services, has been an integral component of Head Start services from the beginning. Yet the utilization of proactive mental health strategies has not been universal by any means. According to the Head Start Performance Information Report (PIR) for the academic year 1995–1996, the percentage of children identified with emotional/behavioral disorders (0.7%) is in stark contrast to the 11–23% estimates of behavior problems in preschool-age children in other studies (Earls, 1980). In contrast, speech and language impairments are by far the most prevalent disability identified, representing 66% of the disabilities diagnosed and 9.5% of all children served by Head Start. For many Head Start service providers, the paucity of mental health referrals is due to a myriad of barriers, from the dearth of effective services to stigmatization. Perhaps more importantly, children and families in need of services are not identified. One reason for poor identification could be due to the lack of appropriate, user-friendly screening procedures. This paper addresses the need for proactive screening procedures and a promising screening procedure for use in Head Start.

PREVALENCE OF EMOTIONAL/BEHAVIORAL PROBLEMS

The generic descriptor, "behavior problems," is one of the many terms describing children and youth who exhibit aggressive, withdrawn, antisocial, disruptive, and/or deviant behavior. Other commonly used terms describing similar phenomena are conduct disorders, antisocial behavior, emotionally disturbed, emotional/behavioral disorders, separation anxiety, and social maladjustment. The actual prevalence of children with behavior problems is very difficult to ascertain. Figures and statistics vary greatly in the relevant literature. For example, Bower (1982) stated that approximately 10% of all students have moderate to serious emotional problems, while Brandenburg, Friedman, and Silver (1990) suggest that at least 7% of all students may have emotional problems serious enough to warrant treatment. A U.S. Government report for the nation as a whole reports that fewer then 1% of all children are currently served

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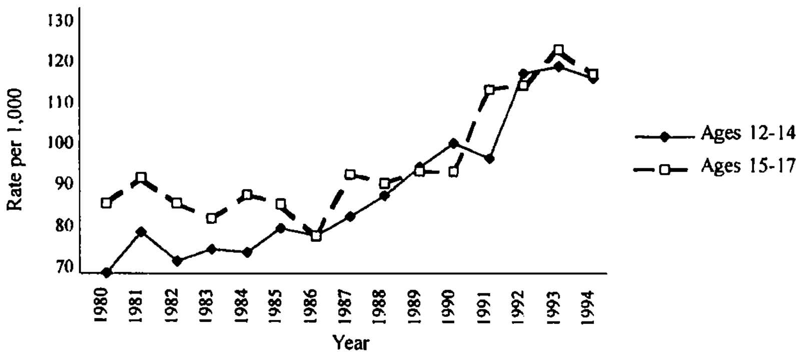
* Although this is the proceedings from a 2-day roundtable on mental health issues in Head Start, the author has provided the complete paper that he presented at that time.

under the category of Seriously Emotional Disturbed which is mirrored with a paucity of referrals for mental health services (Division of Educational Services, 1990). The disparity between prevalence estimates and data on the percentage of children served indicates a significant deficiency in the early identification of children exhibiting serious emotional/ behavioral problems such as antisocial behavior patterns and conduct disorder.

VIOLENT CRIME AND AGGRESSION AMONG CHILDREN

While young children do not commit violent crime (with a few recent notable exceptions), the seeds for such delinquent behavior are frequently sown in early childhood (Patterson, Reid, & Dishion, 1992; Loeber, 1990). While these behaviors are of a different intensity as problem behaviors in later childhood and adolescence, they do stem from the same sources and act as kernels from which more serious and possibly life-threatening behaviors grow. For example, a preschool child is not going to steal cars, but will commit a similarly impulsive act of taking a peer's toy. There is quite a difference between the two acts, the intensity and impact on society, but the relationship between the two behaviors is clear, that is, they have in common impulsivity, lack of empathy, and disregard for social norms. From an overview of children's well-being indicators, the Federal Interagency Forum on Child and Family Statistics found that victims of violent crime are getting younger and younger, matching the rate for older youth 15–17 (see Figure 1, Federal Interagency Forum on Child and Family Statistics, 1997).

Figure 1.
Youth Victims of Violent Crime



DEVELOPMENT OF ANTISOCIAL BEHAVIOR AMONG YOUNG CHILDREN

Researchers now distinguish between two distinct forms of antisocial behavior patterns referred to as early versus later starters, or life-course persistent versus adolescent-limited antisocial behavior (Hamalainen & Pulkkinen, 1996; Moffitt, 1994; Moffitt, Caspi, Dickson, Silva, & Stanton, 1996; Patterson et al., 1992; White, Moffitt, Robins, Silva, & Earls, 1990). Evidence indicates that children who show antisocial forms of behavior early in their lives that (a) occur at a high rate, (b) are severe in their intensity, (c) are displayed across multiple settings, and (d) are diverse in their expression, have acutely elevated levels of risk for a host of negative, long-term developmental outcomes (Day & Hunt, 1996; Garmezy, 1985; Reid, 1993).

Developmental research has confirmed that life-course persistent patterns of conduct disorder and antisocial behavior usually begin in the very early childhood years and follow a pattern of escalation and elaboration through mid and late adolescence (Patterson, DeBaryshe, & Ramsey, 1989). These children display an antisocial behavior pattern at the point of school entry and, in the great majority of cases, they manifest it throughout their school careers. Severe antisocial behavior patterns are one of the very best predictors of delinquency and adult criminality (Loeber, 1990). Stability coefficients for childhood aggression rival those for the stability of IQ (Patterson et al., 1989). Findings that early behavior problems, such as aggression and oppositional-defiant behavior, predict later adolescent and adult offenses suggest the existence of an underlying continuum (Robins, 1966).

Researchers have argued that if children manifesting severe antisocial behavior patterns are not successfully intervened with by the end of third grade (i.e., age 8), this disorder should be viewed much like a chronic disease, such as diabetes (Kazdin, Mazurick, & Bass, 1993; Vitaro & Tremblay, 1994). We cannot cure diabetes, but its debilitating effects can be managed over its progressive course through a sensible regimen of diet, medication, and exercise. Unlike diabetes, antisocial behavior patterns can be treated and possibly remediated with early intervention. Therefore, educators should target and treat children at risk for the development of antisocial behavior patterns as early as possible in order to have a chance of diverting them from a path or trajectory that will prove personally destructive and very costly to society.

IMPORTANCE OF EARLY IDENTIFICATION

The Head Start Program Performance Standards outline mental health objectives (§1304.3–7) that strongly emphasize prevention, early identification, and early intervention for problems that hinder normal develop-

ment (i.e., language deficits, emotional/behavioral problems, etc.). Problems that are allowed to escalate often become intractable and display strong resistance to subsequent intervention attempts. Early intervention(s) can alter the escalation of maladaptive behavior patterns and divert children from the path leading to a more severe disorder (Zigler, Taussig, & Black, 1992). Further, if these behavior problems are not addressed in their early stages, they often lead to serious, long-term, negative consequences (Patterson, 1982; Parker & Asher, 1987). The use of an effective screening system, such as the Early Screening Project (ESP; Walker, Severson, & Feil, 1995), could facilitate delivery of early intervention services and also avert special education referrals in later school years. This universal screening procedure has been recommended by Yoshikawa and Knitzer (1997) as a preferred practice for Head Start programs.

CONVERGENT VALIDITY

One potential problem with any assessment process is that dependence on only one measure can skew results and yield false identification. The use of multiple data sources and determination of the convergence or concurrence of their results are strongly recommended practices to help ensure the most accurate information. The synthesis of information gathered from several sources, methods, settings, and occasions produces the most valid appraisal of child developmental status (Bagnato & Neisworth, 1991).

The key to assessment using multiple data sources is convergent validity (Achenbach, McConaughy, & Howell, 1987). Convergent validity refers to the degree of overlap of variance between different measures of the same construct (Heppner, Kilvighan, & Wampold, 1991). In effective practice, a child assessment would include several types of measures, such as parent and teacher ratings and direct observations. If there is agreement across measures, then the results have high credibility. In eligibility decisions, for example, if a child is rated as exhibiting antisocial behavior in both home and school settings and the behavior's severity is independently confirmed with direct behavioral observations, one could be more confident that the child should be eligible for special services.

SCREENING FOR BEHAVIOR PROBLEMS

Careful structuring of the classroom teacher's evaluation of all children in her or his classroom, in relation to objective criteria that define behavioral "at-risk" status, can yield long overdue improvements in the naturally occurring referral practices of most school systems. At best, current practices appear to be reactive and highly idiosyncratic to the behavioral standards of individual, referring teachers (Gerber & Semmel, 1984),

and, at worst, they are extremely biased in the direction of securing the removal of referred students from the educational mainstream with the goals of increasing classroom homogeneity, reducing classroom management pressures, and improving overall teachability (Ysseldyke, Algozzine, & Epps, 1982; Ysseldyke, Christenson, Pianta, & Algozzine, 1983). Current practices in this important area of educational performance can be improved significantly via the following methods: (a) the adoption of more objective criteria for school-related behavior problems and disorders, (b) structured involvement of teacher-appraisal procedures in the initial screening and assessment process, and (c) the use of "multiple-gating" assessment procedures (Loeber, Dishion, & Patterson, 1984) to provide integrated and multiple sources of data in a cost-efficient screening and identification process.

Multiple gating is a procedure that contains a series of progressively more expensive and precise assessments or "gates" that: (a) provide for the sequential assessment and cross validation of multimethod forms of child assessment and (b) establish a decision-making structure for the aggregation of information produced by different assessment sources. It appears that the climate for adoption of such a model is quite timely given the widespread dissatisfaction that parents and educators have expressed regarding current behavioral assessment practices at both preschool and elementary levels (Jenson, 1984; Kaufman, 1982; Wood, Smith & Grimes, 1985; Yoshikawa & Knitzer, 1997). When combined with professional advocacy for the adoption of more objective and standardized assessment procedures (see Executive Committee of the Council for Behavior Disorders, 1987; Kaufman, 1992), the case for more generically effective practices is highly persuasive.

Walker and Severson (1990) have designed a three-stage, multiple-gating assessment model for the screening and identification of potentially at-risk, elementary-age children that addresses many of the problems in assessment practices alluded to above. The Systematic Screening for Behavior Disorder (SSBD) procedure has undergone extensive evaluation and has been recommended by the U.S. Office of Education as an exemplary Best Practice. Walker, Severson, and Feil (1995) have adapted the SSBD for use with preschool populations via development of the Early Screening Project. The ESP required changes in the definitions and instrument formats in Stages Two and Three of the original version of the SSBD. Items that referred to classroom academic issues were deleted in the ESP and observational measures were redesigned to reflect early childhood development.

The ESP universal screening procedure provides for cost-effective, mass screening of all young children who are enrolled in regular preschool and kindergarten classrooms, and links (a) definitional criteria,

(b) screening and assessment procedures, and (c) normative-based, eligibility decision making into one self-contained system. This model relies heavily upon structured teacher judgment of child behavioral characteristics in the first two assessment stages and uses normatively referenced behavioral observation data to provide independent in-vivo assessments of child functioning within instructional and free-play settings in Stage Three. The results of assessments and decision making in initial screening stages are cross validated by increasingly more intensive assessments in subsequent screening stages.

The system is patterned after models developed and validated by Greenwood, Walker, Todd, and Hops (1979) for the preschool screening of children at risk for social withdrawal and by Loeber, Dishion, and Patterson (1984) for the screening of children at risk for adoption of a delinquent life style. It also provides each child in a regular classroom setting with an equal chance to be identified for both "externalizing" and "internalizing" behavior disorders. These two dimensions cover the broad range of school behavior disorders that occur in both the preschool- and elementary-age range. Achenbach and Edelbrock (1978) and Ross (1980) have argued persuasively for the adoption of this bipolar classification system to govern school-based assessment practices.

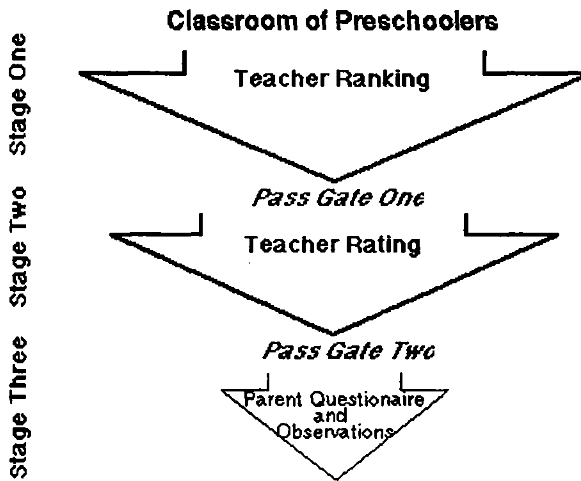
THE EARLY SCREENING PROJECT

The Early Screening Project provides for the early screening and identification of preschool children who are at risk for either externalizing or internalizing behavior disorders/problems. Figure 2 graphically illustrates the screening and student identification processes involved in the ESP multiple-gating procedure. Efficient and low-cost mass screening procedures are implemented in Stage One ESP to identify preschool/kindergarten children who may be at risk for externalizing behavior disorders or problems (Walker et al., 1995). The six highest-ranked children on the externalizing and internalizing dimensions, respectively, are assessed by the teacher on both a Critical Events index and behavioral rating frequency indices.

Stage Two ESP assessments are more complex, intensive, and also expensive in terms of teacher time, but they are conducted on only a small subset of the total number of pupils screened in each classroom. In addition to their screening functions, Stage Two assessments define the specific content of each rated child's behavior problems. Normative criteria on the Stage Two instruments are used to determine whether any of the rated children qualify for Stage Three ESP behavior observations and parent rating assessments (Walker et al., 1995). Qualifying children are then directly observed in free-play social settings and their behav-

ioral levels of antisocial and solitary play are compared to an ESP normative observation database for same age and sex peers.

Figure 2.
ESP Screening Procedure



Beginning in 1991, a series of studies were conducted on the ESP to assess its reliability and validity. These findings have been very promising to date (Feil & Becker, 1993; Feil, Severson, & Walker, 1998; Feil, Walker, Severson, 1995). Subjects (from 1991–94) consisted of 2,853 children, aged 3-to-6 years old, who were enrolled in typical and specialized programs. These children were from preschool and kindergarten classrooms in the following states (the number corresponds to children in the sample): California (517), Kentucky (687), Louisiana (386), Nebraska (65), New Hampshire (25), Oregon (220), Texas (612), and Utah (341).

The ESP reliability and validity data show strong results. The interrater reliability coefficients of most ESP measures are at least .80, which meet Salvia and Ysseldyke's (1988) guidelines for a screening instrument. Good psychometric standards have been attained despite the difficulties inherent in the assessment of young children (Martin, 1986). Validity studies show consistently high relationships to criterion measures: that is, Conners Teacher Rating Scales (Conners, 1989), the Preschool Behavior Questionnaire (Behar & Stringfield, 1974), and the Child Behavior Checklist-Teacher Report (Achenbach & Edelbrock, 1979). Correlations with these criterion measures were highly significant, ranging from .34 to .87, with most above .70.

Further, a discriminant analysis provided a measure of the accuracy of the ESP with both specificity and sensitivity coefficients. Specificity and sensitivity are important criteria when choosing an assessment method (Elliot, Busse, & Gresham, 1993). Sensitivity is the percentage of true positives and specificity the true percentage of negatives (Schaughency & Rothlind, 1991). Results for the ESP show good sensitivity (62%) and excellent specificity (94%), leading to accurate assessments with a minimal risk in identifying a child who exhibits developmentally appropriate behavior.

The Early Screening Project has been found to be user-friendly and reports from staff users and reviewers have been positive regarding both its length and simplicity (Yoshikawa & Knitzer, 1997). One preschool director stated that she expects that use of the ESP will increase the credibility of the staff when they make referrals to local early childhood special education programs. The ESP can make a positive difference in obtaining timely referrals, diagnoses, and follow-through for preschool children showing emotional and behavior problems (Yoshikawa & Knitzer, 1997).

INTEGRATING SCREENING

Conducting screening to identify children who might benefit from mental health services is only the first step. For parents and teachers to really see the benefit and value of the screening process, there must be the perception of appropriate and effective services. Treatment utility is the degree to which assessment activities are shown to contribute to beneficial intervention outcomes (Hayes, Nelson, & Jarrett, 1987). Screening measures have a higher degree of treatment utility when they focus on the behavior changes that are the goal of treatment and are more likely to lead to appropriate and effective individualized intervention outcomes. Sugai and Maheady (1988) also say that among culturally diverse populations, assessment should be linked with intervention.

PUBLIC HEALTH POPULATION-BASED APPROACH

Recently, public health professionals who view violence as a public health problem have begun to consider applying methods that have been used successfully in the past to reduce injuries and deaths from motor vehicle crashes and deaths from cigarette smoking (Koop, 1985; Pathrow-Smith, 1994; Roth & Moore, 1995). This course has been advocated by some researchers (Mercy, Rosenberg, Powell, Broome, & Roper, 1993; Moore, 1993; Walker et al., 1995), and public health agencies such as the Centers for Disease Control (CDC) have begun to support efforts to reduce violence. Key in the effort is the proactive screening of all children and their families for the provision of services.

In order to decrease the incidence of antisocial behavior, it is critical that validated, cost-effective home and school interventions take place early in the school career of children. The beginning of antisocial behavior patterns can be identified at an early age, and these behaviors can be prevented from escalating into more serious and intractable problems. Public policy should include universal screening to provide early detection and early intervention, which have been empirically shown to increase prosocial behavior and reduce aggressive behavior problems (Reid, 1993, Walker, et al., 1996).

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PRESENTER:
Peter Jensen

People have been giving vignettes, and I would like to do the same. I was at a meeting with Jim Harrell and several other people, and at this meeting were senior members of various health and human service agencies. Jim raised the question of what we need to focus on to address the needs of young children. He asked about mental health, and a senior person, whose name and agency shall remain anonymous, said, "Oh no, not mental health!" because he was worried about the stigma of mental health. He comes from a major agency that has responsibilities including children, research, and services. I thought this was a sad commentary on the attitudes at high levels even within Health and Human Services. Hopefully, we will begin to work on that attitude at multiple levels because it exists at all levels. It exists at the family level, at the Head Start program-staff level, and at the administrative level.

I have a bumper sticker on my car that says, "Honk if you're on lithium." This is my small part towards destigmatizing mental health issues. I was once at a traffic light and someone honked at me. I looked in my rear-view mirror and a man was pointing. I thought that something was wrong with my car so I rolled down the window and looked around. I got out of the car and asked what the problem was, and he held up a vial of lithium. The point is that we need to find a way to mainstream mental health.

So I am not sure I agree about avoiding terms like "mental health." Maybe we need a different discipline, or maybe we do need to avoid the terms. However, simply avoiding them partly perpetuates the difficulties and will lead to the creation of a new term that will eventually become pejorative if we do not take on the issues with good information about the brain, and the kind of "food" or nourishment it needs. The food that the brain needs is stimuli from the social and emotional environments. The brain only unfolds in a healthy way if the environments are appropriate and the necessary stimulation for the child is provided. This is such a straightforward, simple message. We have to find a way to take this issue "on the chin," mainstream it, and educate people.

I do think that the term "mental disorder" may be misleading. Regardless, we need to understand that the term simply means a disturbance in behavior, based on who the reporter is and the degree of severity. Obviously, given differences in reporters, settings, and severity, estimates of mental disorder prevalence vary widely. Recent reports from the Center of Mental Health Services converge around a figure of 8–12% of children have significant impairing conditions of "feeling/thinking/behaving." The children who fit into this category are at great risk for ongoing, persistent problems in feeling/thinking behaving. Not identifying or pro-

viding the appropriate services does these children a great disservice.

It is clear from what we are seeing that we face complex difficulties vis-à-vis children's mental health and illness. As we know, there are perpetual disagreements among professional disciplines and philosophies; these same disagreements permeate the larger American society. What is "normal" versus "pathological," or "categorical" versus "dimensional" are important questions. Yet we have a long way to go to resolve the major differences in how we approach these issues across the disciplines of psychiatry, psychology, social work, education, and so forth.

Obviously there are developmental considerations, and what is normal at one age may not be normal at another. We have to consider other factors, such as the possibility that given children's variability from one setting to the next, a disorder may arise in one environment and then spread through additional environments as the child's problems increase. Moreover, problems in early development and early environments may cause the brain to develop in less than optimal ways. Should such environmentally induced difficulties be called "mental disorders?" These are some of the issues that have made it difficult for us to come to agreement on the exact rates of prevalence.

It is possible that labels such as "mental disorder" might be used harmfully. For example, in the history of the term and category of "special education," evidence suggests that minority children were disproportionately categorized in this category. So we must be careful to consider the important role that cultural sensitivity must play in our attempts to work with and change systems and improve our practices. Nevertheless, when we examine how measures such as the Child Behavior Checklist (CBCL) or even diagnostic categories function, we do not see meaningful differences in the rates of problems across different ethnic groups.

In contrast, when we look at national data sets, we find that children in poverty and children of color receive fewer resources. For example, children of color are much less likely to be identified with ADHD and to get appropriate treatment. Lack of identification happens in all settings, not just Head Start. As many as 25% of children who come into primary care have significant emotional/behavioral needs; yet only one in five of these will get identified. The same problems with under-recognition are also occurring in Head Start and in foster care.

At the ACYF, Head Start Bureau, and National Institute of Mental Health levels, we are trying to think about how to develop systems that work together. We are quite excited about the Head Start/university partnerships and have consequently put money into them. We must begin building bridges between our health systems and our mental health identification practices, in order to address the most critical junctures at which children at risk can be identified and given appropriate interventions.

Given the difficulties between our various disciplines and the differences in how we approach our understanding of child development, normal as well as abnormal, we must converse together at all levels as we begin to structure these research partnerships. As "feds," we would be mistaken to think that we, as investigators and administrators, could design "on high" a wonderful public health initiative and inflict it on Head Start programs. Again and again, we have learned that when interventions are designed at administrative levels (e.g., in Washington, D.C.), they will usually not work at the grassroots level. Instead, our models of intervention must begin with the needs and values of the community. However, if we do not begin with community members as partners, they, the supposed recipients of the interventions, are not likely to apply them.

So, as we think about Head Start-university partnerships, we are eager to see where we might increase our abilities to identify and serve children's mental health needs. It is a circular problem: If we do not identify the problems, we will never get the necessary services. If we do not identify the needs and work with communities to define the needs, then we are going to remain in the same situation regarding scarce resources. Currently, despite best efforts, our systems are not providing our children sufficient mental health care and services, so we need to work together as partners to obtain these services. Forming the Head Start-University Mental Health Partnership Consortium to produce solid research evidence will help our families, communities, and policy makers "make the case," thereby increasing our ability to meet children's mental health needs.

PRESENTER:
Gloria Johnson-Powell

I always have a dilemma in presenting at meetings like this because I feel on one level I am recognized as being an academic with research skills. On the other hand, I have been deeply involved in the Head Start community for 30 years and in the community at large in terms of racial ethnic issues for more than 40 years. I try to wear both community and university hats, and determine when to put on each.

I will approach issues of mental health in Head Start from the standpoint of assessing mental health services. Despite the fact that the past decade has seen significant improvements in the responsiveness to children and families with behavioral and emotional disorders, much of the effort has been centered on youth identified as seriously troubled rather than young children exhibiting behavioral or emotional problems not yet identified as severe, or young children with severe problems. One of the real problems that we confront in doing Head Start mental health consultation is the reluctance of parents and teachers to identify children with any kind of problem. It is important to understand why. For poor and minority people referred for services in this country, they usually have ended up in detrimental treatment or mistreatment. However, the values and strategies that have formed the Child and Adolescent Services System Program (CASSP) and the family resource movement generally can help us define the values that should undergird early intervention mental health-related services for young children and their families. I add "and families" because we have to understand that children live in families and we must work with children within a family context.

At the core of these values are the following goals: (a) to enable parents to more effectively meet the developmental and mental health needs of their young children by building on parental strengths and assisting them with concerns and needs; (b) to enable children to experience developmentally appropriate care with whatever special support services are needed in their own homes, family child care and child care settings, Head Start settings, and other community settings, including foster and kinship care; (c) to help parents connect with a range of social and supportive activities that enrich their lives, however depressed, stressed, or burdened they are by the realities of poverty and the demands of childrearing; and (d) to offer family-focused, ethnically, and culturally responsive services that are sufficiently intensive, flexible, and comprehensive to meet the multiple needs of families.

For 5 years, we have had a demonstration project that I named Partnerships and Prevention-Building Rainbows. That name in particular was selected so that we would not have to use mental health terminology. We

were doing prevention services and building rainbows. When I tried to explain to my 3-year-old son how what his mother did differed from what his father did (he was a pediatrician who wore a white coat), he could not quite understand. When I was in San Francisco at a meeting, I saw a great big poster that had rainbows. My son and his father used to spend Saturdays at a construction site in the city looking through the window watching the building go up. I thought that was a nice way to explain it to him. However, I found over the past 35 years that it has also been a wonderful way to explain to parents what our role is. We are here to help children reach the 21st century as productive young adults, happy and secure in their family life, work life, and community life.

It began with my desire to look at the most cost-effective ways of providing services to inner-city poor children. Child mental health services, according to some of the national studies done in prepaid health programs, are 300% more costly than that for adult men, and 65% more costly than those for adult women. That is because for every face-to-face contact that we have with a child, we have many unbillable hours. At UCLA, we had to systematically go through how we were spending the dollars in terms of unbillable and nonreimburseable hours. Therefore, as we begin to track mental health strategies for Head Start, we have to think of reimbursement as one of the issues because we could be in danger of creating a model that will be too expensive to fund at all.

When we looked at the service requirements for the Boston area, we decided that a small, child-guidance clinic would not begin to provide all of the service needs for inner-city children in Boston. We decided that prevention is the way to go in mental health services, and decided to provide mental health services to any major organization in the city that was providing major intervention strategies for children and families. By doing that, we would augment their efforts, cost-share some of the expense of the unbillable hours with their case-management services, and accomplish those tasks that only mental health professionals can do.

I began to conceptualize the competencies of a child psychiatrist, a child psychologist, or a social worker with training in mental health services that only we, as professionals, could provide, and the competencies that we could translate and trade to other professionals or paraprofessionals, such as family mentors. We developed a curriculum for some outreach workers that would be within Partnerships and Prevention-Building Rainbows.

In terms of partnerships and prevention, we learned that each community is unique. Some of the strategies that I could use in communities in Los Angeles were not adaptable to Boston because of the culture of Boston. Every city and every locality has its own culture, its own unique history, and its own population or demographic dynamic between neigh-

borhoods. One has to understand that as one begins to deliver services.

One example of assessing the mental health needs of families in light of the cultural context of the community is our experiences in Boston. First, poor people do not come out for services in Boston. Second, poor people do not want workers in their homes. They are afraid that workers will file a report on them. How can we provide services that will not be intrusive and that will be acceptable? I had one idea after spending 4 years in Africa doing pediatrics and child psychiatry, driving from one village to another to bring the services. We decided to buy a luxury mobile home that slept six and use it as our mobile-service van, with Partnerships and Prevention-Building Rainbows on the outside of it. We went to 12 housing projects and 6 Head Start programs.

Through our experiences in Boston and my experiences worldwide, issues of cultural context seemed paramount. From every corner of the globe, children with different cultural, ethnic, and linguistic backgrounds may be found in our schools, and the families may be found in our health and human service agencies. Yet despite the rapidly increasing diversity of the population of the United States, there has not been much attention to the role of cultural context in the assessment of the development of children, although such studies exist in the anthropological field.

In the update of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), the National Institute of Mental Health convened a special task force to examine the cultural appropriateness of the diagnostic categories. The publication of its findings are a significant contribution to the mental health assessment process and diagnosis, although many of us bemoan the fact that it did not go far enough. However, the application of crosscultural, psychologic, and psychiatric assessments of children still lag behind that for adults because of the lack of research on the cultural influences of developmental psychopathology. The bridge between the cultural and the mental health assessment of children and adolescents is based on four basic premises:

1. Culture is the context or environment in which various kinds of behavior are developed and expressed.
2. Both the context and the content of learning from birth through childhood and adolescence are distinctly cultural.
3. The child's early experiences as a member of an ethnic, racial, or cultural group are significant in shaping behavior, organizing and expressing emotions, and discovering ways to meet social and emotional needs.
4. Information about each racial, ethnic, or cultural group is necessary to understand in order to provide culturally relevant assessment and treatment.

One of my main concerns is addressing issues of training profession-

als to understand the importance of cultural context. In the first book on child psychiatry on this issue that we published, *The Psychosocial Development of Minority Group Children*, Esther Sinclair wrote a chapter on bilingual education. The assessment and treatment of culturally and linguistically diverse children has been addressed in service delivery, but rarely addressed in training programs.

My experience clinically in child psychiatry has spanned several continents in several years. I am trying to put together information to train professionals and parents about cultural diversity and the issues of children's services, particularly children's mental health services. This is a culmination of my experience in academic medicine and in clinical settings in Guatemala, Brazil, and several places in Africa, especially in Uganda where I served as a mental health consultant for the international school there that had more than 25 countries represented.

How do you implement relevant treatment? It is not as easy as one might think. I have been trying to do it for 40 years and I am still stumbling, so I will share that with you. Let us first take a look at why it is so complex. Children are embedded in a complex system that includes factors within the child, the parent, the marriage, the work networks of the parent, the social network of the child and the parent, the school network, the community, the society, and the culture. For us to look at only one system, parent to child, is insufficient for an understanding of all of the factors that impact upon the development of the child.

There are many of us in the women's research area who have bemoaned the emphasis there has been in child psychiatry on the "mal de la mere." Everything that goes wrong with the child is because of something that did not go right with the mother. We who are mothers and fathers understand that we and our children live in a broader context that can impact on our child's development as they impact on us and our families.

Clinicians and service providers cannot rely on stereotypes of racial, ethnic, or cultural groups but must have knowledge about the social and cultural context in which different groups of children grow and learn, recognizing that differences are not deficits. New evidence suggests that psychological development among children is a function of universal cognitive and emotional stages as well as symbolic systems that are themselves dependent on both ecological and psychosocial cultural variables. Erickson as well as Fromm and Bowlby, realized that many social influences above and beyond the impact of the family served as necessary integrative influences on the developing child. Bronfenbrenner and others have emphasized the importance of context in influencing the course and outcome of the development of the child.

These broader views revolutionized social scientists' views of human development with greater emphasis on social and cultural factors, with

social and ecological factors intrinsically related to cultural infrastructures. The understanding of cultural concepts in the facilitation of optimal child development, as well as developmental dysfunction or psychopathology, has enhanced the conceptualization of human development as a function both of the biology of the organism and the individual's psychological, social, and cultural environment.

Since an individual's personality is a function not only of biology within the organism and family dynamics, but also of the social world view, and their view is different from the one we have, the relationship between culture and personality may be difficult to discern. Many times when we are stereotyping various ethnic or racial groups, what we are doing is looking at what we think their personalities are, not realizing that these are social customs that are derived from their culture.

For instance, a young man from Ethiopia came to see me while I was at UCLA. Since he considered me high placed because of my education, he bowed frequently, and when he left the room, he bowed again and backed out. A colleague nearby commented on how obsequious he was. He did not know that the young man was paying us the greatest honor, honoring our knowledge, status in this society, and ability to convey knowledge to him. He came from a wealthy family and was well educated. His bowing out of the room backwards was not an expression of obsequiousness, but of utmost admiration and respect for what we were saying, and our willingness to have him in our program. If you enter into a relationship with a colleague or a student thinking that their manner is obsequious rather than respectful, then the way in which you interact with them will be different.

These concepts of contextual variation among children argue for a multicultural, multifaceted, longitudinal approach to the assessment of developmental outcomes. Therefore, what is the culturologic assessment, as I call it? Everyone says we should be culturally competent. How does one become culturally competent? It is a long process requiring reading. In order to become culturally competent in the same way that one may become medically competent, competent with social service skills, or competent in evaluating children, one has to read. There is nothing that will substitute.

If you are trying to determine what drug to use for a child, you look in the psychopharmacology book at all the reactions and which drug is suitable for the child, and you try to inform yourself. The same holds true if you have a family who is culturally different from you and you do not know the culture. You must take the time to read. That is equally as important as learning the growth and development according to the pediatric charts or knowing what drug to give.

If one reads about the culture, biology, and social aspects of the client's

circumstances, then maybe one will not have a mismatch, giving pharmacological substances to cure something that will actually kill. For example, because the doctors at a prominent Boston hospital did not understand that African American boys are sensitive to Dilantin and get Dilantin toxicity very early, my 13-year-old nephew died. If one does not understand that Asian American children are sensitive to psychotropic medication, one may overmedicate them. As a result of the overmedication, they may display symptoms that are more bizarre. Then, because they are acting more bizarre, one gives them more of the drug.

If culture provides the context in which various kinds of behavior are developed, then we know that the absence of well-being is expressed differently among different cultural groups. Recent research has established some of the different cultural ways of expressing illness or discomfort, and how psychiatric symptoms are, in part, reflections of culturally learned behavior. Consequently, cultural attitudes and beliefs often determine the type of health sought by parents for their children as well as the meaning given to the child's symptoms by family members.

The culturologic assessment attempts to include the cultural, social, and linguistic issues that are pertinent for a multicultural population of children and families. There are several steps to doing a culturologic interview. One is entering the world of the client. To enter the Ethiopians' world, I learned some Amharic words. I found that even though I pronounced them incorrectly, mothers and children enjoyed hearing me try. They would correct me, and in that exchange of their correcting me and my trying to say it right and my saying it wrong and their giggling, we began to make some contact. They at least felt that I was trying to enter their world.

The second step is shaping the content and context of the interviews. Let me give you an example. When I first went to be interviewed by the Dean of Harvard Medical School, it was at 9:00 a.m. and he had a big table filled with food. It looked like he was going to have a group meeting. It turned out that it was all for me, and he was trying to decrease the social distance.

There are many ways that you can decrease the social distance. I decrease it by saying that I am a mother and a grandmother, and by talking about my children and grandchildren. Each of you will find your own way. You increase the perception of sameness by doing that. For Asian American patients, especially for Chinese, one thing is to bring a gift, because bringing a gift to a Chinese family means that you understand them and are ready to welcome them. You have to find those clues. Then you must elicit as much information as possible at each contact depending on the level of comfort.

What is the important data that you have to get now that you have

decreased the social distance and increased the perception of sameness? You need to know something about the country of origin. If you do not know anything about El Salvador, go to your computer, pull it up on the screen, and read about it. At least know something with which you can reach someone.

You need to know the reason for migration, the length of time in this country, the number of generations in this country, the languages spoken, and where. For instance, Vietnamese children end up speaking Chinese, Vietnamese, and English. However, when do they speak those languages and where? Which is the predominant language? What is the family and kinship network? What are the religious beliefs and beliefs about causality? What are the childrearing practices? How are the sex roles different? What is expected of women, of men, of an adolescent child, of a preschool child? In what kind of community are they living? Are they living in integrated or segregated communities? Are they living in a mixed community of immigrants from all over the world?

What is the life space like? You want to step inside the world of the child. What does the child see when he wakes up in the morning? Does he see a great big hole in the ceiling, like I did after the big rains in Boston? What kind of sounds does he hear? Does he hear railroad trains or the sound of birds? Can you step into the life space that the child occupies and know what he experiences from one moment to another, or at least get a sense of it? What about the overt and covert reasons that the parents have for seeking help?

I have gotten into many binds trying to rely just on the parent. Many times parents present the child as having problems when it is the parent who is not functioning well. Can you describe the help-seeking behavior of the child and the parents?

What is the educational attainment of the parents? What is their country of origin? What is their current occupation? What are their experiences with rejection? There are people who come to the United States who were considered very important in their own country. One of the reasons they leave the United States so often is that they have been in the majority culture in their own country, and they find it difficult to take the racism that they experience once they come here, to be pushed into feeling inferior. However, it not only happens to Africans but also to many groups who come and find the racism so vicious and lowering of their self-esteem.

How do you assess the degree of acculturation? By the food they eat, their dress, their social activities? Not everybody in the family acculturates at the same rate. There are lag periods, and some are way ahead and others far behind. That may create certain kinds of issues in the family, the degree of cultural conflicts that the parents are experiencing. We talk

about getting the clinical history, but it is crucial that you mix the clinical history with the cultural formulation and the cultural history.

For instance, by the time you finish your evaluations, you should have some concept of what the cultural identity of the family is in terms of their language and other factors. What are their cultural explanations for the illness? What are the cultural factors related to their psychosocial environment and their levels of functioning? That is where you get a basic understanding of how they are functioning in this new world, this new environment.

You must look at the cultural elements of the clinician/patient relationship before you can do the overall cultural assessment, since they may be reacting to you because you have not been able to relate to them in a cultural way. The assessment process should yield the kind of data that have been described in these questions and more in order to begin to consider the diagnostic categories or the description of the dysfunctional behaviors.

Canino found that the DSM-IV Axis IV (the severity of psychosocial stresses) and Axis V (the global assessment of functioning) are essential components of the diagnostic classification of culturally diverse children. He asserts that the diversity of symptom expression and the multiple cultural pathways in developmental psychopathology often result in overdiagnosis on Axes I and II. Therefore, we have a tendency to overdiagnose culturally different children.

He found that by using the Global Assessment Scale for Children, he was better able to determine who needed treatment and who did not. Only using Axis I of the DSM-IV, he found that 49.5% of the Puerto Rican children needed mental health services. This is highly unlikely. He found that when using the Global Assessment Scale, there were children who had not needed treatment in that 49.5%, who were not severely impaired, and that the seemingly high prevalence of psychiatric morbidity could have reflected the higher levels of stress.

Transcultural child psychiatry is concerned about the impact of cultural beliefs and practices on the development of the psychological well-being of children as well as the development of psychopathology. These include cultural beliefs and practices, childrearing practices, the relationship of the child to the caregiver, and the caregiver's transmission of cultural values and beliefs. When socialization occurs in a society in which the culture of a child is different from the dominant society, the process of socialization and acculturation may be very stressful for children and families. Our new book, *Transcultural Child Development*, put together with funds from the van Ameringen Foundation, will address children and families in cultural context and other related issues.