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ABSTRACT

The paper describes combined public education and community mental health in a preschool educational day treatment program for seriously emotionally disturbed children. The Developmental Therapy model on which the Tacoma, Washington, program is based is described as using five normal developmental stages to facilitate treatment which stresses the role of the curriculum, provides for ongoing evaluation, and defines the staff functions of both public school and mental health agencies. Responsibilities of the children's mental health specialist (support teacher), educator, psychologist, team coordinator, psychiatrist, communication disorder specialist, occupational therapist, and community health nurse are listed. The funding base provides for treatment for children who qualify for public assistance and charges other children on a sliding fee scale. The combined, yet separately identifiable education and mental health goals, make up the individualized educational/treatment program. Also considered is the 7 step referral and assessment process and services to families (including biweekly home visits and parent participation in the classroom). (DB)

PUBLIC SCHOOL AND COMMUNITY MENTAL HEALTH INTERAGENCY COOPERATION FOR TREATMENT OF THE CHILD WITH SPECIAL EMOTIONAL NEEDS

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INTRODUCTION

The direction of this paper is to discuss combined public education and community mental health in a preschool educational day treatment setting. Also examined will be a model used by the Tacoma Public Schools (Tacoma, Washington) and the Tacoma-Pierce County Child Study and Guidance Clinic. This joint effort for services is designed to meet the community mental health committment for services to the seriously emotionally involved preschool child, and the school district committment to offer educational services to the 3 - 5 year old child, as outlined in Public Law 94-142, 1975.

Addressed in this paper is not the child who needs special educational programming and once a week counselling or social work support. Discussed here is the child, who because of the degree of emotional involvement has a need for Day Treatment intervention as an alternative to hospitalization or out of home placement.

Paralelling the educational movement for early screening, assessment, and programming is a similar movement at the community mental health level for early screening, diagnosis and treatment. It would be naive to think that no mental health treatment takes place in the special education classroom. The same can be said of mental health Day Treatment in which the educational process, to different degrees, is provided. A person who has completed training in both mental health and education processes is more and sought after. Meanwhile, the "Art of the Science" and "Science of the Art") has moved to another place that competence in one field certainly an ongoing task in itself. Competence in both is improbable at best.

There are several problems that arise in an attempt for combined agency services. Some of these concerns will be addressed at this time as the need for an appropriate model, problems with interagency involvement, and funding. With the increase in mental health and educational mandates to service the young child, new applications seem imminent. For the most part, these program needs are not paired with sufficient funding base. Thus, services to these young children will most effectively be drawn together through interagency collaboration. Our own combined effort has thus far yielded positive results with a significant number of children beginning the kindergarten/first grade experience in regular classrooms.

DESCRIPTION OF A MODEL

In our times of demand accountability, a well defined program model serves a valuable purpose of identifying structure and method. In a combined mental health and public school effort, it is not enough to have a mental health worker who does things to make a child feel good, or a teacher who is going to teach a few facts. Caring people, doing nice things does not in itself meet our standards of accountability. What is necessary is a specific model that outlines an approach and includes a process for goal setting, goal/growth measurement and evaluation. The type of model selected may not have as much impact on program effectiveness as does the point of team agreement on the type of model selected.

A consistant approach that is followed by all staff, both educational and mental health should be outlined. Thus, a behavioral model may be as successful as a cognitive model or a developmental model as successful as a psycho-dynamic

model. What needs to be avoided is an eclecticism in which each professional maintains their own individual approach. This eclectic approach may often result in valuable time being wasted on the identification of turf and redoing already done work.

For Tacoma's combined efforts, a Developmental Therapy model was chosen. Developmental Therapy, a validated Bureau for the Education of the Handicapped model, meets many criteria that are essential for a combined effort. The model defines curriculum, suggests activities to meet the curriculum, provides intervention strategies, delineates staff roles and insures ongoing evaluation, based on specific developmental goals and objectives. (Wood, 1975)

> The model in its most basic presentation is broken into five stages of development. The stages appear as follows: (Wood, 1975)
>
> I. Responding to the environment with pleasure.
> II. Responding to the environment with success.
> III. Learning skills for successful group participation
> IV. Investing in the group process.
> V. Applying Individual/Group skills in new situations.
>
> This approach uses normal changes in development to facilitate treatment.

The curriculum is considered the primary tool in facilitating change and growth. It is based on the belief that a child's development does not occur in isolated areas, rather the areas of development overlap - influencing and complementing each other. Therefore, while goals are set for communication, behavior, socialization and preacademics, the curriculum does not specify activities designed to meet these goals in isolation of the other areas.

The materials and activities used are critical to the child's success. Children need to be active participants in the process of change, rather than passive receivers of information. Through the use of materials, the children can express themselves and reflect life experiences and processes which they are unable to verbalize. (Moustakas, 1974) (Axline, 1947).

For the preschool child with emotional needs, (stages I and II in Developmental Therapy) successfully participating in the environment, both individually and as part of the group is the major focus. The curriculum, therefore, needs to reflect this. The materials and activities should entice the child to want to participate, and provide for successful outcomes. (Wood, 1975). The activities are also planned to meet as many objectives as possible. The objectives incorporate the skills that the child has accomplished, as well as encourage continued development. Mastery of skills and abilities can be a significant vehicle in the therapeutic process. (Erickson, 1950).

With a group of youngsters with serious emotional needs, intervention stratagies are an important component of a program. This must be reflected in the chosen model. The Developmental Therapy model delineates such methods, based on a child's level of functioning. For stage I and II children, classroom structure and rules are of utmost importance. These children have difficulty organizing themselves and need predictable structure to aid in their organization. Rules need to be clearly

defined, as an additional aid to understanding expectations, and to provide some parameters for behavior. In addition to these group techniques, a variety of individual stratagies are necessary for the young child. These include: body contact and touch, removal from the group, physical and verbal re-direction, verbal interactions among adults and reflection and praise. (Wood, 1972). The frequency and use of one or a combination of these stratagies is dependant on the child's developmental level, and an awareness and sensitivity on the adults part, as to which is/are the most effective for a particular child or situation.

An appropriate model should provide for ongoing evaluation of each child's progress, allowing for continual feedback on developmental levels. The Developmental Therapy model provides sequential sets of objectives in four areas of development: behavior, socialization, communication, and preacademics. These objectives provide the framework for modifying curriculum and stratagies to optimally meet the child's changing needs.

When a program is designed, utilizing dual agencies, it is important to remember that professionals with a variety of backgrounds and training, will be working together. Each staff member needs to draw upon personal expertise and knowledge, and utilize individual experience, yet combine efforts in a mutually supportive system. The Developmental Therapy model provides a framework for defining staff functions. The staff utilized in the Tacoma Program include: a Children's Mental Health Specialist, a certified special education teacher, and a team coordinator. The original Developmental Therapy model allows for a lead teacher, a support teacher and a team monitor. (Wood, 1972). The current situation dictated some modification of this model, whereas the educator assumes the lead teacher role, the Children's Mental Health Specialist becomes the support teacher, and the team coordinator becomes the monitor. Within this system are certain responsibilities shared by the entire treatment team, as well as individual responsibilities within the team.

The responsibilities shared by the entire treatment team include: plan a curriculum to meet the cognitive, language, social, behavioral, and preacademic needs of the children; provide and coordinate materials appropriate to the curriculum; plan the intervention program for school, home and community; provide ongoing regular in-home intervention. In addition to the above roles, individual responsibilities are designated as follows: (Wood, 1975).

Children's Mental Health Specialist (support teacher)

1. Re-direct the children to the lead teacher into the group or toward the materials.
2. Reflect outcomes of behavior.
3. Complements the lead teacher.
4. Keeps the children involved with individual and small group tasks.
5. Deal with crisis.
6. Direct actions to meet the child's immediate needs while moving the child toward the developmental therapy objectives.

Educator (lead teacher)

1. Be a catalyst for individual and group progress.
2. Be the mediator and elicitor of group feelings.
3. Encourage and mold interactions.
4. Creates the classroom atmosphere which allows for self expression by the children.
5. Provide a focal point for participation.
6. Monitors the schedule.
7. Recognizes potential crisis and decides whether intervention is necessary, and cues support teacher to intervene.
8. Presents materials.

Team Coordinator (monitor)

1. Serve as a coordinator for all aspects of the program.
2. Coordinate family services.
3. Observe the class and provide feedback.
4. Provide crisis backup in the classroom.
5. Coordinate intake.
6. Provide leadership for the treatment team.
7. Expand the teams knowledge of developmental therapy.
8. Supervise trainees.

In addition to the treatment team, which is directly responsible for the daily services to the children, there are other professionals which play key roles in the program. Responsibility for these services are shared by the agencies involved. These services include:

Psychologist- Provide initial psychological evaluation; participate in formulation of treatment plan; provide periodic re-evaluation when indicated.

Psychiatrist- Provide initial psychiatric evaluation; participate in formulation of treatment plan; monitor use of medication (when indicated); periodically observe class and provide feedback regarding individual and group dynamics; provide case consultation with the treatment team.

Communication Disorder Specialist-

Provide initial communication evaluations; provide periodic re-evaluation; provide individual language and speech therapy when indicated; provide weekly group lessons, based

on communication objectives and appropriate language development; observe class and provide feedback and in-service relevant to development of effective communication.

Occupational Therapist -

Provide occupational therapy evaluation and re-evaluation when indicated; provide individual occupational therapy when indicated; provide inservice to treatment team regarding individual occupational therapy needs and classroom strategies for meeting those needs.

Community Health Nurse -

Provide in-home nursing services to families as needed; provide periodic vision and hearing screening; referral to needed medical specialists.

FUNDING BASE

While free public education is the right of all children, the same does not apply at this time to children's mental health needs. Rather, it is usually expected that a parent or guardian seeks appropriate mental health services for a child, and then makes payment for those services. In a combined effort for services such as the Tacoma program, it is important to have outlined specifically what parents are paying for. That is, while educational services and the related support services are seemingly the financially free rights of children, no such allowance is made for more comprehensive mental health services. These services, when combined with educational services, are most likely to meet the needs of the child with severe emotional needs.

An essential part of a successful combined effort is a predictable funding base. A major strength of the combined effort idea is the resulting combined funding. This is a move away from the concept of contracting out for services in which a school district or mental health center pay someone else to perform services that they are not in a position to perform. With the combined effort, the educational staff and instructional materials are provided by the public schools, while the mental health staff and the necessary therapeutic materials are provided by a separate mental health budget. In this instance, the mental health funding base is three fold. For those children who qualify for public assistance, funding is based on federal Title XIX monies, matched with state mental health Grant-In-Aid revenue. Those children not on public assistance, pay for Day Treatment Services as set forth by a Clinic sliding fee scale. These monies are the generating base for the mental health budget. Paralleled then, are the public school monies, generated by the number of qualifying children.

INDIVIDUALIZED EDUCATIONAL/TREATMENT PROGRAM

With accountability becoming a major element in programming, a system of measurement of progress becomes imperitive. A major aspect of P.L. 94-142 involves the Individualized Education Program (I.E.P.). This sets forth the plan for each child including specific educational goals and objectives.

Further clarification of the combined, yet separately identified education

and mental health goals, may be arrived at with some minor expansion of the I.E.P. In a situation of combined services, the I.E.P. might actually be expanded to include mental health goals and might appear as an Individualized Education/Treatment Program, (I.E.T.P.). Such an outline allows for clarification of school responsibility for meeting a child's educational needs and specification of mental health treatment plans.

This process assists in resolving at least two concerns. First, it specifies for parents and other observers that there are two separate plans; one educational and the other therapeutic. Secondly, it assists the mental health workers in clarifying both to themselves and significant others, i.e., mental health reviewers, just what is taking place in daily treatment.

In this attempt at combined services, the model chosen allows for clarification of goals in the four specific areas already discussed - behavior, socialization, communication, and pre-academics. In naive terms then, this might appear as the areas of behavior and socialization reflecting treatment issues and the areas of communication and pre-academics, reflecting a broad traditional educational forum.

This portion of a child's I.E.T.P. short term goals might appear as follows:

Behavior:

1. To use play materials appropriately, simulating normal play experience.
2. To wait, without physical intervention by adult.
3. To participate verbally and physically in sittingactivities, such as work time and juice and cookie time, without physical intervention by adults.
4. To participate verbally and physically in movement activities, such as play time, mat time, games, and music activities, without physical intervention by adult.

Socialization:

1. To initiate minimal movement toward another child.
2. To participate in a verbally directed sharing activity.
3. To participate in interactive play with another child.

Communication:

1. To use simple word sequences to command, question, or request of another child or adult, in ways acceptable to classroom procedures.
2. To use words to share minimal information with an adult.
3. To describe simple tangible characteristics of both self and others.
4. To use words spontaneously, to share minimal information with another child.

Pre-academics:

1. To recognize pictures that are the same and ones that are different.
2. To count, with one-to-one correspondence, to ten.
3. To perform eye-hand coordination activities at the 5 year level.
4. To recognize symbols, numerals and written words, that are the same and ones that are different. (Wood, 1975).

REFERRAL AND ASSESSMENT

The administrative end of any agency generally involves a complicated network of paper work and procedures. Attempting to understand and implement one agencies methods often presents a major hurdle in and of itself. This hurdle is heightened when trying to combine and utilize the methods of dual agencies. The goal is to maintain the critical components of both groups methods, yet, combine procedures in such a way as to eliminate duplication of efforts. This involves the relinquishing of some power and autonomy on both sides as steps are made toward an efficient, cooperative system.

The referral and assessment process of the mental health agency, and the school district is an example of such a system. After initial experimentation and struggles, the Tacoma Program has developed a coordinated and sequential process for referral, assessment, and the development of the individualized education/ treatment program (I.E.T.P.). This process progresses as follows:

1. Child Study and Guidance Clinic Intake and application, and Tacoma Public School referral for educational planning. At this time, the agencies also exchange confidential information release forms.
2. Clinic assessment - including evaluations by one or more of the following: Social Worker, Psychiatrist, Psychologist, Occupational Therapist, Communication Disorders Specialist.
3. Clinic disposition - assessment information reviewed, and treatment plan formulated.
4. Parent sharing, to include Director of School Social Work, and Day Treatment Team Coordinator.
5. Registration with the schools; completion of the I.E.T.P. Part I - including treatment plan, necessary support services, and long term goals.
6. Student begins educational day treatment.
7. Completion of the I.E.T.P., Part II - two weeks after student begins program includes short term objectives based on the Developmental Therapy Objective Rating Form (DTORF).

FAMILY INVOLVEMENT

In addition to direct services to the child in day treatment, services to

the rest of the family are often necessary to affect treatment on a comprehensive basis. In the Tacoma program this is accomplished through several different modalities. The responsibility for service is shared by both the mental health staff and the educational staff. Every center has different amounts of time, energy and monies to carry out the comprehensive plan involving the entire family. However, it is these authors' opinion that a child's growth in the day treatment setting can, to a large degree, be measured by the support and involvement of other family members.

Home visits occur on an every other week basis and are carried out jointly by the teacher and Children's Mental Health Specialist. The direction of these visits is primarily sharing class progress, discussion of classroom goals, and materials used to reach goals. This provides parents with continual feedback and allows the teacher and Children's Mental Health Specialist to provide support as to how parents might best work with their child.

Classroom observation and parent participation are encouraged as another modality. This involves the team coordinator observing treatment through an observation window, and providing feedback to the parents regarding staff approach. This is also a time in which behavior and performance can be compared between school and home. Following a short observation period the parent might then move into the classroom assisting as a support teacher. This allows for hands-on participation. Such an observation and participation time might involve: 15 minutes observation; 30 minutes classroom participation; 15 minutes debriefing between parent and team coordinator.

Another commonly used modality is family or individual therapy. This is carried out by the team coordinator. Treatment goals are set dependent on family needs but for the most part are designed to examine the family system as a whole. Family or individual treatment is often necessary prior to a family becoming supportive of the comprehensive plan of the program, or willing to carry out suggested structure at home.

Additional treatment that is scheduled outside of the child's treatment should be attached to the I.E.T.P. This is another way of providing for sharing among program providers as well as keeping parents attune to a comprehensive plan.

As discussed earlier, this shared model is not thought to be the only workable option for combined services. In choosing an alternative model, there should be a process for identifying goals to service the following purposes:

1. Clarifying to parents what mental health and educational processes are happening with their child.

2. Clarifying for administrative personnel just what goals the workers are attempting to attain.

3. Clarifying to staff specific goals set for each child, thus allowing educational and mental health staff to exchange ideas and attempts at meeting goals.

CONCLUSION

It can be expected that as service populations drop in age, the cost and

extent of services will increase; due at least in part, to the increased staff-child ratio. Such service and financial responsibilities may best be accomplished with the use of combined agency involvement. The effect is shared financial and staff responsibility, as compared with the contract model, in which education and treatment responsibility is taken over by another agency.

This paper has been an attempt to describe one example of a combined agency effort for service to children with serious emotional needs. Elements of the program, which have been outlined include:

1. The need for selection of a model.

In a combined effort, it is necessary to have a framework, from which staff from various agencies can operate. This should be a model that staff from the involved agencies agree upon.

2. Components of an appropriate model.

The process of the chosen model should be well outlined. The model should define an approach, delineate staff roles, identify a process for goal setting and growth measurement and provide for program evaluation.

3. The administrative component.

The administrative bodies of all agencies involved, need an identified process for the sharing of administrative responsibilities. This includes the combining of as many paper work trials as possible, in order to eliminate duplication of effort. The program time lines need to be ascertained, in order to avoid the conflict of some budgets running 9 months and others 12 months.

Provision of services to the preschool child with serious emotional needs presents educators and therapists with a multi-facited programming challange. These children may exhibit behaviors ranging from extremely withdrawn, to highly aggressive and acting out. In addition, cognitive development may range from significantly delayed to gifted. Services to this difficult to program population necessitates extensive planning, utilizing a multi-disciplinary team. The needs of these young children and their families, will best be met by the combining of existing community services in conjunction with public school efforts.

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