DOCUMENT RESUME

ED 267 912 PS 015 711

AUTHOR Hutchison, Mary Ann
TITLE Testimony of the Project Director, Head Start Mental Health National Discretionary Grant on Behalf of the American Psychological Association before the United States Senate, Subcommittee on Children, Family Drugs and Alcoholism, Committee on Labor and Human Resources on the Subject of Mental Health for Head Start Children and Families.
INSTITUTION American Psychological Association, Washington, D.C.
PUB DATE 27 Feb 86
NOTE 11p.
PUB TYPE Legal/Legislative/Regulatory Materials (090) -- Information Analyses (070)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Early Childhood Education; Educational Needs; Emotional Development; *Family Programs; Interpersonal Competence; *Mental Health Programs; *National Programs; *Prevention; Psychiatric Services; Psychological Services; *Young Children
IDENTIFIERS *Project Head Start

ABSTRACT

This report represents the testimony of Dr. Mary Ann Hutchison, Project Director of the mental health demonstration and research discretionary grant, "Strengthening Head Start Families: Reducing High Risk Through Mental Health Prevention/Intervention," who discusses the importance of reauthorization of Head Start's mental health component. After a summary of research supporting the need for mental health services for this population, some findings and their implications are presented from the discretionary grant that provides comprehensive mental health services to Head Start children and their families. Historically, Head Start has placed far less emphasis on the mental health component of the program than on other components. It is argued that neglecting the mental health needs of those children and families who would benefit from professional assistance jeopardizes the gains made by the Head Start program. Finally, the testimony urges a commitment to mental health to accomplish the primary goal of Head Start and the promotion of social competence of children and families, and concludes that targeting of mental health funds within Head Start with emphases on prevention, early identification, and rehabilitation is vital. (DST)

American Psychological Association

TESTIMONY
of

Mary Ann Hutchison, Ph.D.
Project Director
Head Start Mental Health National Discretionary Grant

on behalf of

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

before the

UNITED STATES SENATE

Subcommittee on Children, Family, Drugs and Alcoholism
Committee on Labor and Human Resources

February 27, 1986

Mary Ann Hutchison

on the subject of

Mental Health for Head Start Children and Families

1200 Seventeenth St N W
Washington, D C 20036
(202) 955-7600

American Psychological Association

Madam Chair and Members of the Subcommittee on Children, Family, Drugs, and Alcoholism, it is an honor to be invited here today to testify on behalf of the American Psychological Association on the reauthorization of Head Start, and I would like to take this opportunity to commend your outstanding leadership in legislative efforts to provide quality services to children and families in this country and, in particular, the Head Start program.

I am Dr. Mary Ann Hutchison, Project Director of the mental health demonstration and research discretionary grant entitled "Strengthening Head Start Families: Reducing High Risk Through Mental Health Prevention/ Intervention (MHP/IP)", funded by the U.S. Department of Health and Human Services and sponsored by the Latin American Civic Association (LACA) in Los Angeles, California's largest Head Start delegate agency.

In the following remarks, I will discuss the mental health component within Head Start, summarizing research supporting the clear need for mental health services for this population. I will also present some findings from the discretionary grant which I designed and directed that provided comprehensive mental health services to Head Start Children and families. Finally, I will discuss the implications of this research for the broader Head Start program.

750 Seventeenth St., N.W.
Washington, D.C. 20036
(202) 955-7600

Head Start and Mental Health

Since its inception in 1965, Head Start has become the largest comprehensive child development program in the United States, serving over 400,000 children and families annually. While some controversy surrounded the early evaluations of the program, over the past decade evaluations point to Head Start as a model of organizational innovation that has improved the lives of millions of young Americans and their families.

The Head Start program is composed of several different components, including health, education, nutrition, social services, parent involvement, and the inclusion (or "mainstreaming") of handicapped children. In recognition of Head Start's broad developmental approach, the varied components were designed to serve the needs of the whole child. Head Start has undergone a variety of changes over the years, but mental health, a part of the health component, has consistently been the least valued, least visible and least adequately funded of all the components. (e.g., one Head Start agency serving approximately 800 children has a $62,000 Handicap budget, a $60,000 Dental budget, and a $5,000 mental health budget). For the most part, when a child has psychological problems, that child is referred to outside agencies for assistance. However research has shown that this low income population will rarely use available community mental health services. The reasons for this include the stigmata attached to seeking mental health services, their distrust of the bureaucracy and, for the increasing number of ethnic minorities in this country, the lack of bilingual and culturally sensitive counselors. In addition, the highest priority in mental health programming and funding has consistently been for adults, severe pathology,

institutionalization, and aftercare facilities. The lowest priority has been for children, families, minorities, and prevention.

The dearth of mental health services provided to these children and their families is troublesome in light of recent research findings which indicate that between 10% and 25% of Head Start children experience relatively severe psychological and developmental disturbances which, left unchecked, have the potential for producing long range damaging effects, including psychopathology, delinquency and antisocial behavior, and alcohol and drug abuse. Applying these figures to the Head Start population suggests that, in any given year, in addition to the 400,000 children and families who would benefit from mental health prevention services, between 40,000 and 80,000 children in the program would stand to benefit from more intensive mental health treatment services. More evidence of the need for psychological services for children in Head Start comes from Dr. Cynthia Barnes, Executive Director of Manhattan Children's Psychiatric Center which services the borough of Manhattan as the state children's psychiatric hospital. She states that 80% of the children in the hospital had previously been enrolled in Head Start, but only 10% had been detected while in Head Start.

Within Head Start, there has been a strong emphasis placed on the educational, cognitive and physical development of the child. In contrast, far less effort has been expended on the contributions mental health professionals can make in improving the emotional lives of these children and their families. For example, a 1984 study indicates that 90% of Head Start children received medical screenings and, of these children, 96% received the

needed medical treatment; 86% had dental exams and, of these, 96% received the needed dental treatment. In comparison, there are no national data available on Head Start mental health services.

This is the foundation upon which our mental health discretionary grant, entitled "Strengthening Head Start Families: Reducing High Risk Through Mental Health Prevention/Intervention (MHP/IP)", was developed. We set out to determine whether the provision of three mental health interventions, staff training and consultation, parent education and involvement, and in-house mental health treatment services (including short term psychotherapy), would lead to a reduction of psychological and behavioral problems in our population. It is important to note that our project viewed the child and family from a broad, family-oriented perspective rather than from the more traditional, individualistic child-oriented approach. As such, parents were viewed and respected as the primary educators and socialization agents for their children. Given this perspective, our goal was to work with parents and other family members to find ways to enhance their functioning in these roles, rather than supplant their activities. We felt that the most viable means for achieving the primary goal of Head Start - the promotion of social competence for children and families - would result from a focus on existing strengths inherent in the family and on the nurturance of individual and family responsibility. The project stressed a team approach to treatment, where parents, counselors, and teachers joined together to serve the needs of the child and the family. The project was implemented for 3 years in the largest Head Start agency in California, serving 960 children and families. The project was staffed with a licensed mental health specialist (myself) and 5 full time counselors. Our findings represent the third year of the program.

The project provided three differing modes of service: prevention, early identification and treatment, and rehabilitation. Our preventive services were designed to enhance parent-child-teacher interactions both in the classroom and in the home. All parents and staff received a detailed orientation to the program at which time the stigmata attached to mental health was openly addressed. Mental health was presented in a positive, simple, down to earth, and culturally meaningful fashion. Parents were encouraged to attend parent education sessions, and were supported as the primary educators of their children. The staff received comprehensive training and consultation on positive mental health in the classroom and on serving the needs of the individual children in the classroom.

With respect to the second service modality, early identification and treatment, all children were observed by the counseling staff in the first 3 months of the program, and the children in need were referred to mental health for treatment or to the appropriate component. When a child was referred for mental health services, a classroom observation was made, followed by a parent-teacher conference with the mental health counselor to discuss the problem and explain the mental health services. This was followed by a session with the parent(s) and later by a session with the entire family. A recommendation for treatment was then discussed and agreed upon in collaboration with the parent(s). Treatment might include one or more of the following: family, conjoint, individual and/or play therapy. Eight weeks after a case was closed, a review was conducted to evaluate the success of treatment. If problems had arisen, the family could resume treatment. For children in need of long term intervention, services were coordinated with the handicap component and referrals were made to appropriate agencies for continued services.

Let us briefly discuss some of the major findings. Of the 960 children and families in the program, 199 (21%) were referred to mental health. When the referrals were initially made, 75% of the original presenting problems focused solely on the child while 25% focused on the parents/family. After our assessment of the cases, a full 84% of the problems were attributable to problems in the family system. This dramatic change supports our shift from a child centered program to a family centered program. Problems which, before our assessment, appeared to be solely child-oriented (e.g., aggressive behavior, separation anxiety, withdrawn behaviors, speech problems and age-inappropriate behavior, etc.) were found to be related to parental/family problems (e.g., lack of parenting skills, a parent's own unresolved problems, dysfunctional communication patterns, and marital, separation, and divorce problems, etc.). Clearly, had we focused solely on the child, the effectiveness of our efforts would have been limited.

Of the cases referred to mental health, 61% followed treatment to completion, which is quite high for treatment programs. Our success of treatment was based upon evaluations from 3 sources - parents, teachers and counselors. The success in treatment ranged between 88% and 90%.

The comprehensive mental health services of this project cost $100 per child, only a fraction of the increasing costs of special education or the average of $50,000 per year or greater for institutionalization.

Summary and Recommendations

Historically, Head Start has placed far less emphasis on the mental health component of the program than on other components. By neglecting the mental health needs of those children and families who would benefit from professional assistance, we jeapordize the gains made by the Head Start program.

With each Head Start family having an average of 5 people per household, Head Start has the potential to provide services to approximately 2 million people annually. A model such as the one I have described, which provides comprehensive mental health services in the areas of prevention, early identification and rehabilitation, has the potential, over a generation, to enhance the lives of 40 million people.

The Head Start Bureau has begun to recognize the importance of mental health by funding research and demonstration programs from their discretionary fund and by establishing a Mental Health Task Force. Still, I suggest that more can be done to help these families. I would urge the members of this Subcommittee to include language in the reauthorization of Head Start which would strengthen the committment to this component. In addition to continuing research on mental health service delivery systems, Head Start needs to utilize the expertise and knowledge gained from demonstration and research projects, and also replicate their successful efforts. The Head Start Bureau should encourage local Head Start agencies to bolster the mental health component of their health services. Finally, the Head Start Bureau should be encouraged to seek out linkages with other federal agencies and programs, such

as the ADAMHA services block grant, the Child and Adolescent Service System Program (CASSP), and mental health training in order to utilize all available resources.

A commitment to mental health is critical in accomplishing the primary goal of Head Start - the promotion of social competence of children and families. The targeting of mental health funds within Head Start, and an emphasis on prevention, early identification and rehabilitation is vital. More action is needed if mental health services are to become integrated into Head Start programs at national and local levels. The time has come to actively prevent long-term damaging psychological and developmental disturbance through comprehensive mental health services. Only through a commitment to positive mental health services can the social competence and well-being of Head Start children and families be ensured.

Thank you for the opportunity to testify on behalf of the American Psychological Association on the reauthorization of Head Start. If I can be of any further help in your deliberations, please feel free to call on me.

FLORIDA

United States Senate

WASHINGTON, D.C. 20510

February 28, 1986

Dr. Mary Ann Hutchison
29 Navy Street
Penthouse
Venice, Ca., 90291

Dear Dr. Hutchison:

Thank you for your participation in the reauthorization hearing for the Head Start Program. Your demonstration program carried out on a discretionay grant was very interesting and the effectiveness of the intervention you designed was impressive. Your recommendations for legislative change will be carefully considered as the Subcommittee designs the new legislation.

Sincerely,

Paula Hawkins

Paula Hawkins
Chairman, Senate
Subcommittee on Children
Family, Drugs and
Alcoholism