DISSERTATION

Mental Health Services In A Northern Colorado Head Start Program

Submitted by

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WE HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER OUR SUPERVISION BY BRANDI L. CHEW ENTITLED MENTAL HEALTH SERVICES IN A NORTHERN COLORADO HEAD START PROGRAM BE ACCEPTED AS FULFILLING IN PART REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY.

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ABSTRACT OF DISSERTATION

MENTAL HEALTH SERVICES IN A NORTHERN

COLORADO HEAD START PROGRAM

Head Start is a federally funded program that aims to improve the school-readiness of students from low socioeconomic backgrounds. In addition to the educational curriculum, the program provides health resources for its students and their families, including psychological services. This study reviewed the characteristics of psychological services provided in a Head Start program located in northern Colorado. Findings of this study support the necessity of the Head Start mental health component and its direct contributions in providing psychological services to students and families. Results revealed consistency between parent and school staff reports regarding presenting problems and concerns. The most pronounced concerns from both school staff and the parents were problems with the parents' psychological well-being. Additionally, both school staff and the parents most frequently requested counseling services for their psychological and/or socio-emotional issues. Based on these findings, the author discusses various mental health roles assumed by the Head Start Mental Health Provider, including the role of a family-based treatment provider, a broker, collaborator, and a promoter.

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CHAPTER 1

Introduction

In 2005 the federally funded early-childhood education program, Head Start, celebrated its 40th anniversary. The program began in 1965 as the federal government's social change response to the "War on Poverty". Created by the Office of Economic Opportunity (Zigler & Styfco, 1998), Project Head Start was designed to be an eight-week summer course that provided preschool children from lower socioeconomic backgrounds with a comprehensive program to meet their educational, social, nutritional, and mental health needs (Kotelchuck, 1987; Zigler & Valentine, 1979). The political climate at the time, including the inequality between social classes, contributed to the idea that the government was obligated to help underserved groups by providing early educational opportunities. It was believed that an early and adequate education would provide impoverished children with the skills and tools necessary to prevent poverty during adulthood (Hansen & Martner, 1990).

Head Start burgeoned over the next four decades (Zigler & Styfco, 1998) and with the rapid growth came a series of studies focusing on the effectiveness of Head Start. In 1988 a one-year follow-up comparison study found that Head Start attendees made greater improvements on Preschool Inventory and Motor Inhibitions tests than children who either did not attend preschool or attended another preschool program (Lee, Brooks-Gunn, & Schnur, 1988). An additional study found that children enrolled in Head Start

demonstrated greater cognitive and analytic abilities than did a control group of children who did not attend preschool (Lee, Brooks-Gunn, Schnur, & Liaw, 1990). Recently, Anderson and colleagues (2003) conducted a systematic review to evaluate the effectiveness of early childhood development programs, including Head Start. Their findings indicated substantial benefits of early childhood programs, including prevention of developmental delays and increased school readiness. On the other hand, St. Pierre and colleagues (1995) found that, if and when there are positive effects, the effects are often small and are easily impacted by other variables and factors. Moreover, Lee and Loeb (1995) purport that Head Start attendees often end up in lower quality grade schools, thus educational gains made in Head Start often remit by middle-school.

The emphasis on evaluating Head Start attendees continues into the 21st century. More recent research suggests stronger long-term effects moderated by the child's ethnicity (Garces, Thomas, & Currie, 2002). Garces and colleagues found that for Head Start students ethnically identified as white, a significant relationship was found between Head Start enrollment and high school graduation. In addition, this study showed that Head Start students ethnically identified as African-American were significantly less likely to later engage in criminal behaviors than same-aged peers from similar socioeconomic backgrounds. The researchers also found a birth order effects where younger siblings enrolled in Head Start showed more favorable school outcomes than their older siblings (also enrolled in Head Start). The authors partially attribute this improvement to the parent training aspect of the program. They discuss the likelihood that younger siblings benefit from the skills training received by their parents during their elder siblings enrollment.

In 1969 the federal administration of Head Start was transferred from the Office of Economics to the Office of Child Development in the U.S. Department of Health and Human Services. Four years later, in 1973, the mental health component was established (Zigler & Muenchow, 1992). This component required that appropriate psychological services be available to all Head Start children, parents, and staff. Services provided to the parents and Head Start staff members were aimed at assisting them with mental health concerns related to the child (e.g., assistance with managing the child's disruptive behavior). In addition, performance guidelines encouraged "wellness" and "holistic" approaches, adding that psychological services should aim not only to treat existing mental health concerns, but first and foremost to prevent future dysfunction (Hansen & Martner, 1990).

National Data on the Characteristics of the Head Start Child and Family

The impressive growth of the program and its high enrollment rates led program researchers to focus on gathering information about the specific needs of these Head Start children and their families. In 2002, the Office of Planning, Research, and Evaluation in the Department of Health and Human Services conducted a large-scale study (entitled the "Family and Child Experiences Survey" or FACES) examining over 3,000 Head Start children ages 3 and 4 (O'Brien et al., 2002). The sample of children was evenly divided between males and females and approximately 30% of the children were identified as White, followed by African American (28.8%), Hispanic/Latino (27.6%), other (8.7%), Native American (1.9%), and Asian/Pacific Islander (1.3%). The results indicated that over half of the children's primary caregivers were in their twenties and nearly a third were in their thirties (M=30.4 years). Forty percent of the children's primary caregivers

reported a "Married" status while 33% indicated that they were single and had never been married. A majority of the respondents indicated "Vocational or trade school" (41.9%) as their highest level of education while 27.5% had less than a high school diploma and only 2.3% reported having a "College degree or higher". Nearly half of the primary caregivers indicated that they were not employed, with caregivers of Hispanic children having a slightly higher rate of unemployment than caregivers of African American, Asian, Native American, and White children.

While the O'Brien et al. (2002) survey indicated that the average household consisted of 4.6 persons, nearly two-fifths of those households experienced a change in composition over the course of the year (i.e., someone entered or left the household) and it was more often the male entering or leaving. Additionally, almost a tenth of the households experienced a change in the principal adult figure during the year. Finally, at the inception of the study (O'Brien et al., 2002), the average monthly income for the household was only $1,256.

Mental Health Services for Head Start Programs

The need for mental health services for children from lower socioeconomic (SES) backgrounds is consistently supported in the literature. Reasons for services include lower mental health functioning (Duncan, 1994; Gotlib & Avison, 1993; Gould, Wunsch-Hitzig, & Dohrenwend, 1981; Hendryx & Ahern, 1997; Leventhal & Brooks-Gunn, 2003; Offord, 2001; Smith, J., 2000), increased risk for child maltreatment and neglect (Drake & Pandey, 1996; Gillham et al., 1998; Lee & Goerge, 1999; Wolfe, 1999), and a lack of social support and resources for the family (Belle, 1982; Klebanov, Brooks-Gunn, & Duncan, 1994). Moreover, Arnold and Doctoroff (2003) outlined the importance of

early education for children from low SES backgrounds and recommended embracing empirical knowledge on mental health and other areas as a buttress to a successful early education program. They indicated that one can increase the likelihood of later achievement through early intervention for psychological dysfunction and by fostering early academic skills and interest (Ramey & Ramey, 1998; Raver, 2002).

Although research supports the need for adequate mental health services for children and families, mental health is still considered an underdeveloped area for Head Start and tends to receive less attention than other services (Yoshikawa & Zigler, 2000). For example, in a large Health Component study examining Head Start programs across 23 states and Puerto Rico (Keane, Connell, O'Brien, & Close, 1996), researchers found the mental health component the most difficult aspect to investigate because of the "lack of clarity among staff and parents regarding the scope of the mental health domain and its place within Head Start".

Researchers continue to explore methods for addressing the mental health needs of Head Start families. Recommendations for strengthening mental health services have included: more holistic and family-focused approaches, improving multicultural competence among mental health providers, increasing collaboration between mental health services and other Head Start components, providing training and internship opportunities for mental health professionals, supporting Head Start staff who work closely with the mental health needs families, and remaining committed to scholarly research focusing on various areas of early childhood development (Piotrkowski, Collins, Knitzer, & Robinson, 1994). In addition, it has been argued that Head Start mental health

services need to address the marked prevalence of substance abuse disorders among Head Start families (Washington & Bailey, 1995).

Prevalence of Developmental/Mental Health Concerns and Common Treatments

A necessary position for implementing the Head Start mental health provision is that of the mental health coordinator. The mental health coordinator follows structured guidelines on how to implement the mental health component based on Head Start's primary goal and mission (Hansen & Martner, 1990). As such, each program is able to cater their mental health program around these guidelines, to meet the needs of the specific community and the population it serves. These coordinators have also participated in research projects by providing substantial information regarding mental health issues within the Head Start population. Keane, O'Brien, Connell, and Close (1996) interviewed 37 mental health coordinators across the U.S. and Puerto Rico for the Health Component Study. They found that the coordinators most frequently cited Behavior Disorders (48.6%) as the most serious mental condition among their students, followed by Hyperactivity/ADD (27%), Change Within a Family (27%), Physical/Sexual Abuse (24.3%), Effects of Substance Abuse by Others (24.3%), and Emotional Problems (18.9%).

Keane and colleagues (1996) also looked at the type of mental health services provided by Head Start programs. The top three most frequently cited services indicated by the mental health coordinators were: informing parents of service needs suggested by examinations and screenings (100%), informing parents of available treatment services (100%), and identifying service providers (100%).

In addition to interviewing mental health coordinators, researchers for the Health Component Study (Keane et al., 1996) also gathered information through parent interviews. They found that the most common problems reported by the parents were speech and hearing problems (40.8%), cognitive/developmental delays (29.8%), emotional disorders (25.3%), social behavior problems (15.8%), and hyperactivity or ADD/ADHD (13.3%). The parents cited speech therapy as the most common form of treatment (33.5%), followed by psychotherapy (29.8%), special education (28.2%), and medication (7.4%). O'Brien et al. (2002) also found that the parents' participating in their study most frequently cited impairments in their child's speech/language development as their primary concern (13.9%). This was followed by: Multiple Disabilities (5.5%), Other Reported Disability (3.5%), and Emotional/Behavioral Disorder (2.4%).

A study focusing on region-specific aspects took place in a large suburban community in Montgomery County, Maryland (New, Razzino, Lewin, Schlumpf, & Joseph, 2002). Research with the national research demonstration program, Starting Early/ Starting Smart (SESS), evaluated the use of mental health services by Head Start families enrolled in programs around Montgomery County. The researchers concluded that nearly 33% of the 290 children in the study were identified (by parents) as having clinically significant behavior problems. Nonetheless, almost 80 % of the 33% had not received any child-focused psychological services. Moreover, they found in their community that teachers and parents often disagreed on the presence of behavior problems. This is consistent with the discrepancy found in the Health Component study

between parents' and mental health coordinators' reports of most common mental health problems (Keane et al., 1996).

Another region-specific study was conducted in the early nineties and examined Head Start programs in Denver, Colorado. Mowder, Unterspan, Knuter, Goode, and Pedro (1993) analyzed 510 case records of children age two to five. The data covered a 2-year period and results indicated that parents most frequently cited their child's socio-emotional problems as their main concern (39.3%). This was followed by concerns regarding: speech/language development (23.8%), family (23.8%), attention difficulties (11.7%), developmental problems (6.3%), health and medical ailments (5.3%), and motor coordination impairments (1%). Contrary to previous literature, Mowder and colleagues found agreement between the parent and teacher reports of most common problems. Similar to the parents' report, school staff cited socio-emotional problems (55%) as the most common problem amongst their students. This was followed by speech and language delays (23.8%), familial concerns (23.8%), attention deficits (11.7%), developmental problems (6.3%), health and medical ailments (5.3%), and motor coordination impairments (1%). Mental health referrals most often resulted in staff consultation, followed by: class observation, informal assessment, parent consultation, formal assessment, and outside consultation. Based on the findings, Mowder et al. (1993) recommended that services focused on socio-emotional development should be offered more widely throughout the program. In addition, the authors strongly encouraged future studies to examine the reliability of their findings.

Present Study

The present study provides an analysis of the type and extent of psychological services provided to Head Start Children in a rural school district in northern Colorado. The researchers examined seven years (over an 9-year period) of archival Head Start data exploring the following questions regarding the Mental Health Component in Head Start: 1) most frequently reported presenting concern; 2) consistency between parent and staff concerns; 3) most common primary role for the Head Start Mental Health (HSMH) provider; 4) how many contacts typically occur between the HSMH provider and the referral source; 5) how many contacts typically occur between the HSMH provider and the parent/caregiver; 6) what is the average length of time between an initial referral and completion of the case; 7) what is the frequency of non-respondents; 8) does an association exist between presenting concern and final classification (e.g., completed); 9) are there any differences in how the referrals are distributed among the four classification categories (i.e., completed, monitor, active, non-respondent); and 10) do referral characteristics predict referral outcome?

CHAPTER 2

Method

Participants

Two hundred and seventy nine mental health referrals were included in the study. Participants included children and families enrolled in a Head Start program in northern Colorado who were referred to the Head Start mental health team. The participants were initially referred during one of the seven academic years included in the study: 1996, 1997, 1999-2002, and 2004. The remaining school years (1998 and 2003) were not investigated because the examiners were unable to access the administrative database due to corrupted computer files in the Head Start administration data storage system.

All referrals were made from Head Start classes located in a school district in northern Colorado. This school district covers 1,856 squares miles, is the ninth largest in the state, and hosts two early childhood resource centers. Head Start enrollees made up 35% of the students in the district's early childhood program. The majority of Head Start students were identified as Hispanic (55%), followed by: White (35%), American Indian/Alaska Native (4%), African American (3%), Asian or Pacific Islander (2%), and Undeclared (1%). The average size of the Head Start family was 3.8 persons per household and their average combined annual income was $11,700 - which was slightly below the poverty line (Poudre School District, 2006).

The county in which the school district was located significantly lacked government funded mental health services and had the least number of government funded resources in the entire state. Hence, the mental health component of the Head Start program was one of the few programs that provided government funded psychological services to low-income families (Poudre School District, 2006).

Procedure

All the children and families included in this study were referred to the Head Start Mental Health Team (where the referrals were processed and monitored). This team included the Head Start Mental Health (HSMH) provider. The HSMH provider's responsibilities included providing consultation to teachers and staff regarding the students' mental health issues and behavior management problems, conducting home visits with families, and consulting with/referring to mental health professional in the community. The team also included a Licensed Clinical Psychologist (whose duties included supervising the HSMH provider), School Psychologist, behavioral consultant, social worker, student services coordinator, and a special education coordinator.

During these meetings, the mental health team discussed the referred students/families and classified them as "active", "monitor", "completed", or "non-respondent". An "active" referral was an open case where current action was being taken by the HSMH provider to provide services. A case that was categorized as "monitor" was one where the presenting concern has been addressed and serviced but the mental health team deemed it necessary to continue checking-in and updating to ensure that the mental health team met the child/family's needs and they no longer required psychological services. A case was considered "completed" when the mental health team

either directly met the child/family's needs regarding their presenting concern and/or when the family was referred to another community professional for treatment of the mental health concern. A "non-respondent" case was one in which the referred family failed to respond to numerous contact attempts made by the HSMH provider. These attempts included phone calls and written correspondence. In many cases the HSMH provider also collaborated with school staff in attempt to briefly meet with the parent during the parent's regularly scheduled pick-up and/or drop-off of their child.

As a regular procedure, the Head Start (HS) staff (usually a teacher) filled out a referral form, which included information regarding the presenting concern and previously utilized interventions. Demographic information was maintained in administrative databases while referral and treatment characteristics used for this study was collected from archival information available in client files. Information retrieved from these files included the following:

Demographic Information: Childs' gender, age at time of referral, ethnicity, and family income.

Referral Information: Referral source (HS staff who referred the child/parent to the HSMH provider), presenting concern, previously utilized interventions, and expectations for service actions.

Treatment Information: Types of services received, number of contacts between the HS staff and the HSMH provider, number of contacts between parent/caregiver and the HSMH provider, length of time between initial referral and completion of the case, and testing materials administered to the child and/or parent/caregiver.

The files were coded for the aforementioned information by the researchers and their trained assistants. The files were then double checked by another research team member to correct errors and to maintain reliability across coders.

CHAPTER 3

Results

Descriptive analyses of the data indicated that, while over half of the students in the Head Start program (under investigation) were Hispanic (55%); the majority of the 279 students referred for psychological services were White, non-Hispanic males (60%). English was the most commonly used language in the home (83%), followed by Spanish (10%). Approximately 57% of the referrals were made by the student's HS teacher, 36% were made by the HS Family Service Provider (FSP), and the remaining referrals were made by "Other" HS staff (such as an Occupational Therapist or the Early Childhood Behavioral Consultant).

Characteristics of mental health referrals

The most commonly cited Psychological Concern from the HS staff (usually the teacher or FSP) was a "need for counseling for the child's parent(s)" (64%), followed by "general inappropriate behavior" exhibited by the child (35%). Thirty-four percent of the referrals included psychological services requests for the child's disruptive behavior at home and another 34% of the referrals were made because of concerns about parental depression/anxiety. Results indicated that the majority of HS staff requested that numerous presenting concerns be addressed by the HSMH provider. When referrals were followed-up on by the HSMH provider, the mental health concerns reported by the parents were similar to the referral sources' concerns. The most commonly cited concern

by the parents was a need for counseling for themselves (39%) followed by concerns regarding the child's disruptive behavior in the home setting (19%). (See Table 1). Of note, although parents were able to cite as many concerns as necessary, most of the parents presented in a crisis situation and seemed to only cite the single most pressing concern. Hence, while HS staff frequently indicated several concerns, the majority of HS parents reported only the most emergent concern.

The most frequently cited expectation from the HSMH provider was to get involved by providing general counsel to the parent (42%); followed by requests for help with providing the parent with effective child management techniques (38%). Results examining the Types of Services Delivered indicated that the HSMH providers most frequently responded by consulting with the parents via telephone contact (31%), followed by providing the parent with a referral for counseling to outside an agency (26%), in 12% of the referrals the primary role of the HSMH provider was to aid the parent directly with child management techniques, and in 5% of the cases the HSMH providers themselves met with the parent(s) to provide direct psychotherapy services. (See Table 2). As these results show, it was common for HS staff to cite numerous service expectations for the HSMH provider. Given limited time and resources, however, these findings indicate that HS staff were often unable to deliver all the requested services and could only provide the most efficient service that most immediately met the student's and family's mental health needs.

Data was also collected regarding any Prior Strategies attempted by the teacher or family service provider before to referring the student for psychological services. It was

reported that the teacher most frequently attempted to discuss their concerns with the child's parent (53%), followed by verbal redirection (32%), and time-out (30%).

Longitudinally, the data indicated that "counseling for the parent" remained the most frequently cited concern from the Head Start staff throughout all 7 years examined by the researchers. This was also the most frequently cited concern, for 5 of the 7 years, indicated by the parents when the HSMH providers followed-up with them. During the remaining two school years, the parents reported disruptive behavior in the home setting as their most pressing concern.

On average, only 7 cases per year (SD=4) were classified as non-responders. Overall, 71% of the 279 cases were classified as "completed". A chi-square goodness of fit analysis revealed that significantly more cases were classified as "completed" and significantly less were non-responders than would be expected by chance, $\chi^2(3, N = 273) = 333.9, p < .01$. Regression analyses were conducted to explore longitudinal trends and to identify any possible predictors of outcome. For example, the researchers examined whether presenting concern predicted outcome (e.g., a "completed" versus "non-respondent" case). However, no statistically significant trends were found.

The average length of time between the HSMH providers' initial contact with the child's family and final contact with the family was approximately 3 months (M=83.65 days, SD = 71.24). The average number of contacts between the HSMH provider and the family was 4 (SD=3.9) and the average number of contacts between the HSMH provider and the Head Start staff was 6 (SD=17). Additionally, frequent contact between the HSMH provider and the teacher/FSP significantly predicted increased contact between the HSMH provider and child's family, $\beta = .033, t(262) = 2.24, p < .05$.

Relationships amongst referral and treatment characteristics

Chi-square tests of association were used to explore possible relationships between the presenting concern and outcome, and the primary role of the HSMH provider and outcome. Results indicated that children who were referred for general inappropriate behavior had more "completed" classifications and less "non-respondent" classifications, $\chi^2(3, N = 273) = 13.10, p < .01$.

Finally, regarding the primary role of the HSMH provider and outcome classification, it was observed that when the HSMH providers' primary role was to perform a classroom observation, there were fewer "completed" and "non-respondent" classifications (and greater "active" and "monitor" classifications) than when the HSMH provider had a different primary role, $\chi^2(3, N = 273) = 11.68, p < .01$.

CHAPTER 4

Discussion

Head Start is a dynamic, multifaceted, and comprehensive program that equips families from lower-socioeconomic backgrounds with educational, social, health, and psychological resources previously consider a luxury and attainable only by those with the financial capacity to access them. The necessity of Head Start, however, continues to be a topic of debate amongst educators, politicians, and psychologists. In a recent issue of the APA's *Monitor on Psychology*, an article on the efficacy of the program argued for the necessity of the program by discussing how Head Start leads to substantial gains in students' reading abilities (Munsey, 2006). Still, to evaluate Head Start solely on its educational efficacy is to deny the complexity of a program that claims to take arms against one of society's most formidable social maladies – poverty. Therefore, in addition to the program's educational components, one must also consider the advantages of the additional resources provided to students and families. One such resource is the Mental Health Component, which requires that all Head Start families and staff members have direct access to free psychological services through the program (Hansen & Martner, 1990).

Implementation guidelines indicate that the program's mental health services vary according to the community's needs and its students. This allowance for subjective interpretation has resulted in a divergence of the structure of these services and has

blurred the picture of how mental health services should be structured. It is essential, therefore, to closely examine individual programs to ensure an accurate understanding of students' needs and to improve the efficacy of services delivered.

As initially discussed, the present study aimed to answer several questions surrounding Head Start mental health referrals in a northern Colorado school district. The results were as follows: 1) The most common presenting concern for both HS staff and parents was a request for counseling for the students' parents; 2) Contrary to previous studies, the researchers found consistency between parent and HS staff concerns with both groups citing the same top four problematic issues (see Table 1). Moreover, the present study found consistency in primary concern across all 7 years ("counseling for parents"). Parents also reported the same presenting concern for 5 of the 7 years, with "disruptive behavior in the home setting" being their primary concern for the remaining 2 years; 3) The most common primary role for the Head Start Mental Health (HSMH) provider was to provide phone consultation to the parent followed by referring the parent to an outside psychological services agency; 4) Six contacts typically occurred between the HSMH provider and referral source; 5) There were an average of 4 contacts between the HSMH provider and the parent/caregiver; 6) Three months was average length of time between an initial referral and completion of the case; 7) An average of 7 cases per year were classified as non-respondents; 8) Regarding associations between presenting concern and treatment outcome, case who referred for general inappropriate behavior had more "completed" classifications and less "non-respondent" classifications than those that were not referred for general inappropriate behavior; 9) Overall, there were

significantly more completed cases than non-respondent cases; and 10) The researchers did not find any significant predictors of treatment outcome.

The aforementioned findings provided a more comprehensive picture of the mental health needs of the Head Start staff, students, and families in this particular school district. The author used this information to identify the multiple roles for the HSMH provider that may prove necessary for a mental health program that truly meets the needs of the individuals it serves.

A Family-Based Mental Health Program

The present study focused on analyzing 7 years, across a 9-year period, of archival Head Start data obtained from mental health referrals for students and families. Results of the present study attest to the necessity of the HS mental health program in that there were significantly more "completed" referrals and fewer "non-respondent" referrals than would be expected by chance. .

Unlike previous research (New et al., 2002; Keane et al., 1996), the investigators found consistency between Head Start staff (usually the teacher) concerns and parental concerns – both groups citing the parent's socio-emotional well-being as the primary issue. This concern was prominent for all but one of the seven years studied. The integral relationship between parent and child mental health is evident across many studies. Parents' mental health is closely associated with stronger disciplinary skills and greater involvement in treatment programs (Baydar, Reid, & Webster-Stratton, 2003; Leung & Slep, 2006). Additionally, parents with numerous mental health problems are more likely to have children who struggle with inpatient psychological treatment than parents without mental health problems (Gullick, McDermott, Stone, & Gibbon, 2005).

Baker, Blaccher, and Olsson (2005) also found that parents reported more depressive symptoms and lower marital adjustment when their preschooler exhibited behavior problems.

The direct correlation between the existence of psychopathology in parents and child mental health problems has long been supported by the literature (Beardslee, Versage, & Gladstone, 1998; Cummings & Davies, 1994; Fendrich, Warner, & Weissman, 1992; Weissman, Warner, Wickramaratne, Moreau, & Olfson; 1997). As previously mentioned, the mental health component was initially designed to provide services to Head Start parents with the notion that parental concerns were somehow related to parenting behavior (i.e., child management techniques). Therefore, the importance of our findings lies in identifying how a Head Start mental health program can incorporate family-based treatment directly related to parenting. The challenge for this school district's Head Start mental health team – and any other school district with similar referral characteristics – is to engineer a program that effectively serves the psychological needs of parents while still functioning within the mental health component guidelines and federal regulations.

The Head Start Mental Health Provider as a Broker

In an article discussing the impact of the health component in Head Start, the authors – one being Head Start's founder – commends the program's health providers for taking on a role they refer to as "brokering" (Zigler, Piotrkowski, & Collins; 1994). They define this role as a didactic "link" between the parent and community resources and agencies. In essence the role of brokering is to provide psycho-education to Head Start parents so that they are connected to the best and most appropriate resources available to

them. Zigler and colleagues argue the importance of this role with a reminder of the many barriers parents from lower SES backgrounds often face when attempting to access adequate healthcare for their families. As previously stated, the county in which the school district under investigation was located did not have many government-funded community mental health resources and the Head Start mental health program was one of the few available to families from lower SES backgrounds. Given the lack of resources and results indicating that the most common presenting concern for both parents and Head Start staff was parental mental health, it was not altogether alarming that the most frequently requested psychological services was counseling for the parent and the most common primary role for the HSMH provider was connecting the parent to a financially feasible community provider, or agency, for psychological services. These results demonstrate the applicability of Zigler et al.'s (1994) "brokering" role that is often required of the Head Start mental health provider.

If these findings are determinants of future mental health referrals, they suggest that perhaps the mental health component should expand to include comprehensive family therapy services as an integral aspect of the program - as it has been demonstrated that one cannot assume that Head Start mental health will only reach as far as the students in the classrooms, especially when the larger community lacks such resources. If it is not feasible to incorporate more family-based services, "brokering" protocols for providing adequate family counseling services should be developed and implemented when necessary.

The Head Start Mental Health Provider as a Collaborator

Results showed that the frequency of contact between Head Start staff and the HSMH provider predicted the number of contacts between the parent and the HSMH provider. This evidence suggests that a close consultative relationship between school staff and the mental health provider may act as a buttress for the relationship between the parent and the mental health provider, such at that increased contact between the provider and HS staff may encourage involvement from the parent.

The implications for a stable working relationship among all those involved in Head Start were demonstrated by Webster-Stratton and colleagues (2001). They found that involvement in a teacher- parent training partnership resulted in greater parent-teacher bonding and improved both parenting and teacher skills. In addition, the children whose parents participated in the program exhibited decreased behavioral problems up to a year later. Other researchers (Stormshak, Kaminski, & Goodman, 2002) found that home visits from familiar Head Start staff increased parental involvement in Head Start program activities and improved parenting skills. Other research has also noted the invaluable impact an effective working relationship between Head Start staff and parents can have on the child's development. Undoubtedly, it is important that the mental health provider see their role not only as providing psychological services to the students and their families – but also as a collaborative member of a multidisciplinary early childhood education team.

The Head Start Mental Health Provider as a Promoter

Finally, while some treatment approaches focus on remedying psychopathology, others advocate for the prevention of mental illness by promoting well-being and life

satisfaction as an essential provision of psychological services. In their definitive manual on mental health in Head Start, Hansen and Martner (1990) encouraged "wellness" and "holistic" approaches, adding that psychological services should aim not only to treat existing mental health concerns, but first and foremost to prevent future dysfunction. Simeonsson (1994) also stresses the need for a greater emphasis on risk prevention by promoting resiliency and well-being in children. Happiness and well-being have been associated with increased family engagement, decreased stress, and greater physical health (Veenhoven, 1988).

The parents in the present study demonstrated a considerable need for counseling services provided through the Head Start mental health program. As previously discussed, the significance of this finding can be linked to research supporting the juxtaposition of parent and child well-being. For example, it appears that optimism acts as a protective factor for mothers of preschoolers with behavior problems, such that greater optimism was significantly correlated to maternal well-being (Baker et al., 2005). In addition, emotionally competent and happy parents tend to have preschoolers who better understand their own emotions and exhibit more positive emotions when with peers (Denham, Mitchell-Copeland, Strandberg, Auerbach, & Blair, 1997). The Determinants of Parenting Process Model (Belsky, 1984) suggests that parents' personal psychological resources directly contribute to their psychological well-being. Voydanoff and Donnelly's (1998) research examining this model revealed that formal support (meaning supports outside of one's social network) and increased neighborhood resources act as protective factors to parents' psychological well-being. Baker and colleagues (2002) also examined the relationship between parent and child well-being

and found that parents of preschool children with developmental delays reported significantly higher levels of parenting stress than parents of typically developing preschoolers.

The present study addressed existing pathology by focusing mainly on referral and treatment characteristics. However, considering our findings on consistent reports of parent psychological distress and the research on parent and child well-being – it is best practice that the Head Start Mental Health provider embrace Hansen and Martner's (1990) emphasis on a wellness approach, and remain firmly committed to enhancing and promoting adaptive functioning in Head Start children and their families.

Prospective Research

Head Start is most often recognized for their efforts in improving the school-readiness and educational competency of its students. The results of this study, however, give support for the serviceable, and often overlooked, role that Head Start plays in sustaining the mental health of its students and families. This study also reveals that the program is not only making psychological services available but that the teachers and families are utilizing these resources and they frequently follow through until the referral is completed and the family's mental health needs have been met.

Future studies should continue to focus on region specific analyses in order to examine the unique needs of each community. Additionally, it is important that the reliability of these studies be examined to identify any national trends. Moreover, researchers should explore any predictive determinants and longitudinal trends of referral outcome. It is suggested that future studies also include a supplementary component in which they assess the status of the referral post-referral to an outside agency or

practitioner. Finally, it would be beneficial if researchers begin to develop a body of literature specifically focused on promoting mental health and well-being among Head Start children, families, and staff.

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Table 1

Psychological Concerns by Staff and Parents

Head Start Staff		Parent	
Psychological Concern		Psychological Concern	
Parents' mental health	64%	Parents' mental health	39%
• Depression/Anxiety	34%	• Depression/Anxiety	11%
General Inappropriate Behavior	35%	Disruptive Behavior at home	19%
Disruptive Behavior at home	34%	General Inappropriate Behavior	11%

Table 2

Primary Expectation for Service from the HSMH Provider and Type of Service Received by the HSMH Provider

Expectation for Service		Type of Service Received	
Counsel parent	42%	Crisis management	31%
Aid parent w/ child management techniques	38%	Referred to outside agency	26%
Classroom Observation	27%	Taught child management techniques to parent	12%
Referral to outside agency	23%	Met with parent(s) for counseling services	5%