SYSTEMS-BASED PRACTICE
EARLY CHILDHOOD SYSTEM

SYSTEMS-BASED PRACTICE: EARLY CHILDHOOD SYSTEM OBJECTIVES*

Note: Throughout this module, the use of the term “young children” refers to infants, toddlers and preschool-aged children ages 5 and under.

Knowledge
The resident will demonstrate an adequate knowledge of:
1) Previous research that demonstrates the importance of early relationships in child development, and the implications this research has for early childhood program development. (1,2)
2) The multiple systems involved with young children and the organizational structure of these services at a state and local level. (1-5,7-11)
3) Services available to young children at a state and local level. (1-5)
4) The purpose and target population of early intervention programs. (1-4)
5) The purpose and structure of the Head Start program and Parts B and C of IDEA (Individuals with Disabilities Education Act. (1,2)
6) The role of other early childhood providers, such as pediatricians, nurses and early interventionists. (1-12)
7) The roles of child protective services and the legal system for young children and their families, who have been validated (substantiated) as abused, neglected or abandoned. (1-12)
8) Other diagnostic systems for infants and toddlers, such as the Zero to Three classification system and the Research Diagnostic Criteria-Preschool Age (RDC-PA). (1-12)
9) When age-based transitions between service programs occur in local areas. (1,2)
10) The standards for quality child care and its importance for infant mental health and child development. (1-12)
11) The principles of wraparound services and how these are applicable to the care of young children. (1-12)
12) The multiple roles of a child psychiatrist including advocate, consultant, system navigator, medical case manager, diagnostician, psychotherapist, and psychopharmacologist. (1-12)

Skills
The resident will demonstrate the ability to:
1) Collaborate effectively with multiple players involved with infants and toddlers, including the family and other service providers. (1,2,4,5,8-11)
2) The ability to engage families in an effective partnership based on respect for and understanding of developmental niche and culturally relevant parenting practices. (1,2,4,5,8-11)
3) Make appropriate referrals of young children for additional services, such as Head Start, preschool special education programs, Infant and Toddler Programs, and speech, physical, and occupational therapies. (1,2,4,5,8-11)

* Parentheses refer to systems-based practice competencies in the RRC Program Requirements. See Appendix 1 for complete list of competencies.
4) Act as a case manager to support families with age-based service transitions. (1,2,4,5,8-11)
5) Demonstrate flexibility and a willingness to play multiple roles in the community-based care of young children. (1,2,4,5,8-11)

**Attitude**

The resident will demonstrate the commitment to:

1) Appreciate the centrality of the young child’s relationships with caregivers and the impact of the family environment. (1,2,4,5,9-11)
2) Maintain a commitment to providing trauma-informed care to children and their families. (1,2,4,5,9-11)
3) Recognize the importance of early identification of emotional and behavioral health needs for young children. (1,2,4,5,9-11)
4) Recognize the value of interdisciplinary approaches to serving young children and their families. (1,2,4,5,9-11)
5) Advocate for young children and their families’ health and well-being. (1,2,4,5,9-11)
OVERVIEW

This module will help the reader understand the many services available to young children with developmental and mental health challenges. The reader will also learn that each state organizes these services in different ways. The module will also familiarize the reader with existing barriers and gaps in the organization of systems and funding mechanisms that may complicate the delivery of appropriate services to young children and their families.

I. INTRODUCTION: WHAT RESEARCH ABOUT INFANCY HAS BEEN INFLUENCING STATES TO CHANGE THEIR POLICIES?

In order for states and local communities to provide high quality services for young children, they must base the design of their programs on sound scientific research. For example, in their review of child development research and public policy, the authors of Neurons to Neighborhoods: the Science of Early Childhood Development clearly state that strong, loving, caregiving relationships are essential to normative psychological development. They write:

“Virtually every aspect of early human development, from the brain’s evolving circuitry to the child’s capacity for empathy is affected by the environments and experiences that are encountered in a cumulative fashion, beginning early in the prenatal period and extending throughout the early childhood years. The science of early development is also clear about the specific importance of parenting and regular caregiving relationships more generally…” (p. 6)

Thus, as one of their primary goals, community-based early childhood programs must make the preservation of relationships between young children and their parents/caregivers.

In addition, both basic science research and outcomes research can provide insights into how to best develop programs. Courchesne et al. found that by twelve months of age, young children who would later be diagnosed with autism had significantly larger head circumferences and brain volumes than typically developing children. This basic research provides support for the early identification of children at risk for autism using such tools as the Modified Checklist for Autism in Toddlers (M-CHAT) and the development of specific programs to provide treatment to children in this age group at risk for autism.

David Olds et al.’s research on the long-term benefits of nurse home visitation during pregnancy and in the immediate post-natal period underscores the benefits of such a program in the prevention of anti-social behavior and substance abuse as the infant develops into adolescence. The fifteen year follow-up showed significant reductions in these behaviors in contrast with a group of pregnant mothers who received standard pre-natal care. The research of Olds et al., then, can inform the development of community-based prevention programs aimed at reducing adolescent criminal behavior.

To play a role in the development of effective community-based services for young children, the child psychiatrist must have a comprehensive knowledge of the relevant research.
II. LOCAL AND STATE ORGANIZATIONAL STRUCTURES FOR SERVICES FOR YOUNG CHILDREN

Navigating the service array for young children can be a complex task, as often the elements of the service array for young children are administered by several state agencies. For example, a three year old foster child with speech delays, spina bifida and frequent, severe tantrums may be receiving services from Child Protective Services, the local school district, the community mental health center and the state agency charged with providing services to children with physical disabilities.

In addition, the administrative structure for many of these services may vary from state to state. For example, there is significant variation across the U.S. in how early childhood services are administered at the state level and local levels. Frequently, early intervention services are administered by the same state agency that provides child welfare services; two such examples are Arizona and Vermont. In Maryland, the Department of Education administers both the early intervention and special education programs for pre-school children. In New Mexico and Massachusetts, early intervention services are administered by the state Department of Health.

To be an effective health care provider and advocate for young children with developmental and behavioral health needs, the child psychiatrist must have a good working knowledge of the organizational structure for all needed early childhood services on both the local and state level.

III. THE SERVICE ARRAY

*Early Intervention*

Early intervention programs are focused on improving the function of children with intellectual disability, cerebral palsy, genetic conditions/syndromes, and those at high risk of developmental disabilities due to other biological conditions or environmental risk factors. Once the child and family are assessed, an individualized family service plan is developed by a multidisciplinary team including the parents. There is an emphasis in the planning process on coordination of services and providing access to needed therapies, such as speech, occupational and physical. Eligibility for early intervention services in many states extends beyond documented developmental delay to include environmental risk and the presence of emotional disturbances. Early intervention services are available up to approximately three years of age. Then, the child may be eligible for early childhood special education services. A video describing the early intervention services and parent inclusion can be seen at [http://www.fsnenc.org/early-intervention-video](http://www.fsnenc.org/early-intervention-video/).

The national agenda for an early intervention system for infants and toddlers with established disabilities culminated with the passage of the Education of the Handicapped Act Amendments of 1986, with continuing refinements incorporated into the Individuals with Disabilities Education Act (IDEA) that was reauthorized in 2004. Part C of the act states: “to develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention services for infants and toddlers with disabilities and their families.”
Structural components of the system included establishing eligibility criteria and a process to ensure that all children meeting those criteria in a state were served. A “child find” system and public awareness program were included to promote awareness of children’s developmental problems by parents and professionals and to encourage early detection and identification.

Special Education Services
According to federal law (IDEA, Public Law 108-446), children with documented impairment (physical, cognitive, or behavioral) that interferes with the ability to benefit from instruction in the general classroom curriculum are eligible for special education services in a public school from ages 3 to 21. Public schools are obligated to provide a nondiscriminatory evaluation for any child suspected of having a disability and parental consent is required prior to the evaluation. Early referral for such an evaluation when emotional disturbance or developmental delay is suspected is essential. The purpose of the evaluation is to determine whether a child has a disability and, if present, to establish the educational needs of the child. A child is usually evaluated by a multidisciplinary team of professionals that uses a comprehensive assessment process to address the child’s strengths, interests, goals, and needs. The multidisciplinary team must follow specific guidelines during the evaluation of the child. The key mandates are that a number of tests must be used to determine if the child has a disability and that parental input must be included. Once a disability is identified, an individualized education program (IEP) is developed with the parents and the school team. The IEP is based on the strengths of the child, the concerns of the parents, results of the recent evaluations, and the academic, developmental, and functional needs of the child. After age three, the public schools also become the gateway for all needed therapies (physical, speech and occupational).

Federal funding for IDEA services is received by the state education agency and distributed to the local school districts. Federal funds cover only about 10% of the total cost of special education services and the remainder is funded by the state and local school districts. In addition, the federal government caps the number of students in special education in each state to 12% of the total number of school-age students. This accounts to some extent for the variability of the application of the law across states and districts.

Head Start
Head Start is a federally funded program that started in 1965 and promotes school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social and other services to enrolled children and families. The Head Start program provides grants to local public and private non-profit and for-profit agencies to provide comprehensive child developmental services to economically disadvantaged children and families. There is a special focus on helping preschoolers develop the early reading and math skills for school readiness. In 1995, the Early Head Start program was established to serve children from birth to three years of age, pregnant women, and their families. Significant emphasis is placed on the involvement of parents in the process. Funding for the program goes directly from the federal government to local grantees. The federal government provides 80% of the yearly cost to operate a Head Start program, and the remaining 20% must come from a “local match” or “in-kind” contribution.
Collaboration with other community agencies is central to Head Start’s mission and service delivery design. Coordination and collaboration is occurring in many states and at the local level all over the U.S. Each state has a Head Start-State Collaboration Office that helps provide a link between the state pre-kindergarten, child care, private providers, and Head Start. Many states have state early care advisory councils to bring all of the important stakeholders together to promote integration of the early education system.11

Health Care
Pediatricians and family practice physicians are most often the first and primary contact for young children and their families with the health care system. The high frequency of well-child visits in the infant and toddler years offers an excellent opportunity for pediatricians to monitor the general development and specific social and emotional development of a child. Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) for mental health is required at each visit with a child. Pediatricians are usually the first to identify developmental and behavioral concerns, e.g. feeding and sleep problems, withdrawn behavior, impulsivity and oppositional behavior, and special issues of vulnerable young children with medical problems. The concept of a primary medical home is important for a child and their family for continuity of a relationship with a caring provider who knows the child. This helps a parent feel more comfortable in asking questions about developmental concerns they may be having. Pediatricians offer basic mental health care to children and their families by doing initial screening for and beginning assessment of behavioral health problems. Pediatricians also give advice on promoting good social and emotional growth and good parenting practices. When problems become severe enough that a pediatrician can no longer manage them in the office, formal mental health consultation to pediatricians is important. An especially critical time is when newborns have spent time in a neonatal intensive care unit (NICU). Mental health consultation and support is very important to families during the NICU stay and upon receiving their child home and in follow up. Consultation and linkage to formal mental health assessment and treatment in their community are critical parts of an early childhood system of care.

Child Care
Child care workers see children for many hours a day and can be the first to identify behavioral and developmental needs. There are federal and state requirements that monitor the quality of child care settings. Nevertheless, the National Institute of Child Health and Human Development (NICHD) Early Child Care study found the majority of child care center classes for children less than 2 years old did not meet recommended guidelines for group size and adult-to-child ratio.12 Many states require continuing education classes for child care staff, often linked to greater reimbursement rates. These classes will ideally focus on increasing the expertise of child care staff in promoting the basic social and emotional needs of the children in their care and assisting the child who is having behavioral difficulties. The Center for the Social and Emotional Foundations of Early Learning (CSEFEL) has a Web site with a wealth of materials for child care and other early childhood providers that is very useful for continuing education about promoting social and emotional growth and managing behavioral health problems. Many states are providing mental health consultation to child care settings to assist child care staff in working with children with behavioral health needs.

Child Welfare

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Professionals working with children are required by law in most states to report to child protective services serious suspicions of abuse or neglect of a child. Many young children unfortunately must enter the foster care system at early ages for their protection because of abuse and/or neglect. Approximately 30% of children in foster care are under the age of 6. Trauma experienced prior to removal from their family and the trauma of separation from their family must be addressed with foster care children. There are specific evidenced based practices to treat the social and emotional impact of trauma, such as child parent psychotherapy or adaptations of cognitive behavioral therapy. The child welfare system needs to promote the concept of trauma-informed care, which implies an awareness of the effects of trauma on behavior and the provision of a recovery-oriented treatment approach which avoids re-traumatizing the child and parents. Screening for mental health and developmental needs should be done for all children entering the foster care system as children in foster care have higher rates of these disorders than the general population. A comprehensive mental health assessment for all children on removal from their family is a federal requirement and should be done periodically throughout their time in foster care. It is particularly necessary when a child shows signs of behavioral health need. Mental health care should ideally be organized through a child and family team that includes birth and foster families and others involved in the child’s life. Mental health providers should be trained in the specific needs of foster care children including the effects of disrupted attachments and the needs for loving and committed caregiving.

**Family Court**

When children enter the foster care system they come under the responsibility of family court, sometimes called juvenile court or dependency court. The family court is responsible for making decisions about the custody of the child and it rules on termination of parental rights. Family courts operate under the mandate of Adoption and Safe Families Act (ASFA), a federal law passed in 1997, the goal of which is to shorten the time between when a child enters the child welfare system and the time that child achieves placement permanency. When children have been in foster care for more than 15 of the past 22 months, ASFA requires the county child welfare agency to return the children to their parents or to terminate parental rights and free children for adoption or other permanent alternatives for the child. ASFA also changed the meaning of reasonable efforts and established that reasonable efforts to return a child home need not be made when aggravated circumstances are found to exist by the court. Family courts in many states have also begun collaborating with service providers in offering innovative interventions to improve parent-child attachment and address parental trauma and substance abuse. For example, Zeanah and his colleagues have developed a program in Louisiana for the comprehensive evaluation of children placed in the foster care system that worked with both the birth parents and the foster parents. The program resulted in a significant reduction in the maltreatment of the child in care and subsequent children by mothers who were enrolled in the program.

**Developmental Therapy Services**

Young children with developmental delays will often require access to ongoing therapy services in order to maximize their potential. These therapies usually include speech, physical and occupational and are accessed as part of early intervention prior to age three. After age three, these therapies are available as part of a pre-school special education or Head Start program. The need for developmental therapies is determined by assessments completed when a child entered...
these programs. The need must be documented in the Individual and Family Service Plan (IFSP) in early intervention or in the Individualized Education Plan (IEP) in pre-school special education programs.

_Mental Health Services_

**Identification and Diagnosis**

Early identification of the young child’s social and emotional behavioral health needs is critical. Mental health consultation to early childhood settings is a very important way to identify young children with behavioral health needs. Consultation to maternal-infant home visiting programs, Early Head Start, Head Start, child care, pre-school and pre-K school programs and IDEA Part C Infant and Toddler programs ideally should be available throughout all states. As teachers, child care workers, early childhood professionals, and pediatricians and their office staff identify a child with social and emotional needs, a mental health consultant to staff can help the staff program more appropriately for a child’s needs or more directly assess a child with input from their family. An example of such a consultation program is Massachusetts’ Child Psychiatry Access Project.

Until 1994, the Diagnostic and Statistical Manual was the only diagnostic classification system available for the diagnosis of young children, but many clinicians found it of limited usefulness with this population. In that year, the Diagnostic Classification: Zero to Three (DC: 0-3) was introduced, a significant advance for several reasons. The DC: 0-3 adapted a number of established diagnoses such as depression and anxiety in order to better describe these disorders in infants and toddlers. In addition, the DC: 0-3 and its revised version, DC: 0-3R introduced two new diagnostic categories: Relationship Disorders and Disorders of Regulation. The Relationship Disorders category identifies maladaptive interactional patterns between mother and child. Disorders of Regulation “are characterized by the infant or young child’s difficulties in regulating behavior and psychological, sensory, attentional and motor or affective processes, and in organizing a calm, alert, or affectively positive state.” Florida was the first state to use the DC: 0-3 for reimbursement purposes in 2001. A “crosswalk” was developed between the DC: 0-3 and ICD-9 so that early childhood mental health clinicians could effectively bill for their services to young children and their families. Several other states have subsequently developed their own “crosswalks” to assist with reimbursement. In 2002, the Research Diagnostic Criteria – Preschool Age (RDC – PA) was also introduced, providing another set of diagnostic criteria of this age group.

**Treatment Planning**

An emphasis on collaborating with the child’s parents and caregivers is an essential part of developing a treatment plan. If needs cannot be met in the early childhood setting, the child and family can be referred to an office-based early childhood mental health clinician or program including a free-standing infant mental health clinic for follow up and more direct treatment. Therapy for infants always involves a parent with the child in dyadic therapy. Parents can be supported to relate, attach and pick up their child’s communications to them better. Toddlers and young pre-school children can engage in play therapy. The clinician can directly work with the child with or without their parent present. Involvement with family and caregivers is a critical component of treatment with all children.
If a child needs more intensive mental health treatment, many states have therapeutic nurseries, which are partial day programs for young children often accessed through early intervention or pre-school special education programs. A child and adolescent psychiatrist can provide consultation directly to early childhood settings, consultation to clinicians working with early childhood programs, or directly providing assessment and therapy to the child and their family.

Maryland currently has mental health consultation available to all child care settings statewide with plans to cover mother-infant home visiting programs and IDEA Part C Infant and Toddler programs. Head Start programs nationally are required to have mental health consultation available.

**To be an effective health care provider and advocate for young children with developmental and behavioral health needs, the child psychiatrist should be aware of the full array of services available to young children on the local level and be willing to help families access these services.**

**IV. SERVICE TRANSITIONS**

There are multiple age-dependent transitions for young children receiving services in the early childhood system of care. Specialized home-based and clinic-based services for children who have spent the first weeks of their lives in Neonatal Intensive Care Units (“NICU grads”) vary in the length of program follow-up and also in the robustness of their coordination with local early intervention programs. Denise Merrill, in her article “Six Simple Steps to Building a Medical and Early Intervention Transitional Coalition,” describes one state’s efforts to build a strong coalition:

> “The state of Colorado developed such a coalition, which consisted of nurses, therapists, social workers and various state agencies, community centers, and parents of special needs children. They met for two years to develop the basic principles and a guidebook that implements the plan to ensure that children at risk for developmental delay are identified and referred to community-resources. This group was also successful in writing and implementing an interim IFSP [Individualized Family Service Plan] for use in the NICU.”

However, Ms. Merrill indicates that these coalitions are rare across the country. Thus, the responsibility for ensuring a smooth transition between services often falls to primary care physicians and others with a special interest in the community treatment of infants.

Typically the transition from early intervention to school-based services occurs at age three. Upon entrance into school-based services the children’s needs are re-assessed and the young child and their families are linked to the needed services. There is a great deal of variability in the length of time it takes to schedule the initial evaluation and then to become linked to the needed developmental therapies and other services. Children typically “age out” of specialized pre-school services by age 6, though there is some variation across the country in the age of transition into the community-based system of care for older children and adolescents.
Each state and local area will vary in how much support is given to the family in managing these service transitions. These transitions may be easier in systems of care where there are dedicated case management services for young children.

To be an effective advocate for young children and their families, the child psychiatrist must be aware when aged-based transitions between services programs occur in their local area. The child psychiatrist must also be able to act as case manager as needed to support families through these service transitions.

V. INDIVIDUALIZED SERVICE PLAN/USE OF WRAPAROUND

The principles of wraparound (individualized service planning/child and family team process) are as applicable to the community-based treatment of young children as they are to the treatment of older children and adolescents. Programs such as the Community Wraparound Initiative in Lyons, Riverside, and Proviso Townships in Illinois use these principles to provide needed services and supports to both the young children and their caregivers who have a chronic mental illness or a substance abuse diagnosis:

“...Staff at the Community Wraparound Initiative has learned the benefit of working with the entire range of strengths and needs with which families enter services and of drawing on informal and formal supports to offer the parents what they need to be better caretakers of their children.”

In Arizona, the state’s Division of Behavioral Health Services has implemented the use of the Child and Family Teams for all children and adolescents. Their “Practice Protocol: Working with the Birth to Five Population” clearly indicates that use of these principles is integral to the system-based care of infants, toddlers and pre-school age children.

In the absence of a community mental health center or specialized program for young children using the child and family team process, the child psychiatrist may choose to use the principles of wraparound in their consultation and/or treatment of infants, toddlers and pre-school children. The mobilization of both professional and natural supports can be essential to stabilizing the family of a young child with multiple medical, developmental and mental health needs. For example, linking a single mother of a young child with complex needs to a support group may be the key to improving her ability to effectively parent her child.

To be an effective system-based care provider for young children, the child psychiatrist should use the principles of wraparound (child and family team process) in all practice settings.

VI. CONCLUSION: THE MULTIPLE ROLES OF THE CHILD AND ADOLESCENT PSYCHIATRIST IN PROVIDING SYSTEM-BASED CARE FOR CHILDREN AND ADOLESCENTS WITH DEVELOPMENTAL DISABILITIES
To be an effective health care provider and advocate for infants, toddlers and pre-school children, the child psychiatrist must be flexible and be willing to play multiple roles in their community-based care. These roles include:

- **System Navigator**: to assist families by having a good working knowledge of the organizational structure of the services available for young children on the state and local level. The System Navigator must also assist with transition from service array to service array as the young child ages out of early childhood services.
- **Medical Case Manager**: to assist with access to services or to identify and collaborate with the local providers and case managers of services for young children (where they are part of the service array for the early childhood population).
- **Advocate**: whether it is as part of a child and family team (individualized service planning/child and family team process), or simply as a member of the community, for access to needed services. The child psychiatrist may also need to be an advocate for the child and their family with the broader medical community to obtain needed medical or psychiatric services.
- **Medical Member of a Child and Family Team**: the child psychiatrist can identify those future needs for the team that are dictated by the child’s developmental and medical conditions.
- **Diagnostician**: to use the DC: 0-3 to identify appropriate foci for treatment in this age group. To be able to assess for both the psychiatric needs of the young child, but also to recognize the psychiatric needs of the young child’s caregivers.
- **Psychotherapist to the Child**: to provide or refer as necessary for the needed psychotherapeutic treatment.
- **Psychotherapist to the Family**: to provide or refer as needed for family therapy or behavior management training.
- **Psychopharmacologist**: to judiciously use psychopharmacological intervention when necessary as part of a comprehensive treatment plan.
APPENDIX 1*

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
2) coordinate patient care within the health care system relevant to their clinical specialty;
3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
4) advocate for quality patient care and optimal patient care systems;
5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,
6) participate in identifying system errors and implementing potential systems solutions.
7) know how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;
8) practice cost-effective health care and resource allocation that does not compromise quality of mental health care for children and adolescents;
9) advocate for quality patient care and assisting patients in dealing with system complexities, including disparities in mental health care for children and adolescents;
10) work with health care managers and health care providers to assess, coordinate, and improve health care;
11) know how to advocate for the promotion of health and the prevention of disease and injury in populations; and,
12) instruct in the practice of utilization review, quality assurance and performance improvement.

REFERENCES


OTHER RESOURCES


Center for Social and Emotional Foundations of Early Learning – train the trainers compendium of knowledge for early childhood settings. [www.vanderbilt.edu/csefel.uiuc.edu](http://www.vanderbilt.edu/csefel.uiuc.edu)


National Technical Assistance Center for Children’s Mental Health at Georgetown University Center for Child and Human Development. *Early Mental Health in a System of Care. Early Childhood Mental Health Consultation*. [www.gucchd.georgetown.edu](http://www.gucchd.georgetown.edu)


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Early Childhood System – Discussion Vignette I – Trainee Version

You are a consultant to a pediatrics practice and have been asked to see Max, a twenty month old “NICU grad” who presents with ongoing developmental delays and poor sleep. Max’s parents appear exhausted and are concerned that Max’s only words are “Momma” and “Dada.” Max and his family received some nurse visitation as part of a community-based NICU follow-up program, but that ended almost a year ago. Max’s parents are unsure how to access needed services for him.

1. How would you proceed with this referral?

Max is referred to you again at 34 months. He continues to have speech delays and now will have tantrums when he cannot communicate his needs effectively. Max’s parents are quite anxious because they have been told by the early intervention program that they must stop providing services to him in two months.

2. How would you advise the family now?
You are a mental health consultant to a Head Start program. One of the teachers asks you to consult on Jack, a 4½ year-old boy whose escalating aggression has made them uncertain that he can be kept in the program. You have an initial meeting with Jack’s mother and gathered the following information from the interview. Jack’s mother appeared disheveled, tired, and depressed. Jack lives with his mother in a two-bedroom apartment. His mother left his father due to domestic violence three months ago. Jack witnessed his father hitting his mother when he was drinking, and once she sustained a serious injury, which he observed. She has custody of Jack but allows him to visit his father every other weekend. Jack has become increasingly aggressive at home and school. He bites his mother when frustrated. He hits and kicks his peers without provocation. He has trouble getting to sleep most nights. His behavior is noticeably worse after visits with his father. Earlier this week he threatened to kill himself. His mother is afraid of him because she found a knife under his bed, and she locks her bedroom door at night so he won’t come into her room.

1. As a consultant, how would you address the safety concerns presented by this case?

2. Once safety issues are addressed, what services would you recommend to Jack and his mother?

3. Please describe the role of a child and family team in this case and who might be included:
One of the team members wants to know more about Head Start and asks you later:

4. What is the goal of the Head Start Program?

5. Describe the funding for Head Start Programs.