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Mental Health Practitioner's Perspective of Early Intervention Treatment Barriers for Young Children and their Families

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by

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

ABSTRACT

Young children are showing an increase in behavioral and emotional disturbances. Children are showing precocious knowledge of information about drugs, sex and violence. This research project reviews previous findings for causes and intervention for these behaviors. Early intervention, family barriers and access barriers concerning mental health treatment were themes that were continuously discussed in the existing research. This study focused on those themes and surveyed 29 professionals about the family and access barriers that families and children face in regards to preschool mental health treatment. The participants were surveyed anonymously and the findings were analyzed for common themes. The results indicated that insurance, transportation, lack of family support and parent involvement are the main barriers that professionals encounter when working with families and children. Early intervention and parent involvement are the keys to a child's future success according to current research. Implications for policy, practice and research can be drawn due to the lack of research focusing on specific interventions for the preschool population and the increase in mental health diagnosis in preschool aged children.

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INTRODUCTION

Mental health services for all people have been continuous issues with providers and insurance companies. Children's mental health services and needs have increased within the last 20 years. Children with unmet mental health needs during their early stages of life and development can and may lead to problems later in life including depression, drug/substance abuse, problems with the law, educational difficulties, and poverty (Keller, K. and Fox, R., 2009). According to Schmitz, C. L., & Hilton, A. (1996), children have more emotional and behavioral issues than they did 40 years ago, and the number of under referred children for services is growing.

According to the 2005 U.S. Census Bureau, 228,000 children from birth to age 3 are affected by a disability (Tomasello et. al., 2010). Roughly 5-7% of children receive a mental health service at any given time. It is estimated that 20% of children have a diagnosable condition (Manning, 2009). The lack of preschool specific information has led to further research the topic of barriers that influence children being effectively served in early intervention programs and successfully completing treatment.

Policies and Acts have been created throughout history to assist those children in need of mental health service. The first movement began in the early 1800s when people in the United States started to develop child-specific interventions. Since then, there have been numerous frameworks and organizations to separate child needs and services from adult needs and services. The Education for All Handicapped Children Act was passed in 1975 which mandated that states provide services in the least restrictive environment possible to fit the needs of the child. However, 12 years after the Act was passed, states still reported that even for those children who

were most in need of mental health services, the services were not appropriate and/or readily available (Brignewatt, 2010).

To address meeting the needs of children more effectively, the Child and Adolescent Service System Program (CASSP) was instituted in 1984. The programs purpose was to focus on the system of care and emphasize collaboration between multi-agency systems. In 1992, yet another program was formed to fund services that are using the system of care approach. Even though many laws and programs had been developed, children were still not receiving services, services would be terminated prematurely, services were underutilized and services were many times not culturally appropriate for the population it served (Brignewatt, 2010).

The most recent Act to be put into place is the Individuals with Disabilities Education Act (IDEA). IDEA was first passed in 1990 and has been updated as recent as 2009. IDEA defines serious emotional disturbance in terms of the child's ability to learn, potential for interpersonal relationships, behavior, feelings, mood, and physical symptoms (Schmitz & Hilton, 1996). IDEA is a policy to monitor those mental health and educational services provided to children between birth and age five that show an emotional disturbance (Mahoney, 2007). The children that are served through IDEA are those with developmental disabilities, substantial risks of developmental or social-emotional problems and are likely to require special education services when they reach school age (Mahoney, 2007).

Preschoolers are learning about and witnessing difficult life issues including domestic abuse, drug abuse, violence, sexual practices and/or killing/death (Edlefsen, M., & Baird, M., 1994). Preschoolers do not have the capability to understand why or how these things happen. For some children, this exposure is part of his/her everyday life. According to the National Center for Children in Poverty "between 9.5 and 14.2 percent of children between birth and five

years old experience social-emotional problems that negatively impact their functioning,

development, and school-readiness" (Cooper, 2009, p3).

Multiple studies note that intervention works better the earlier it is presented (Axford, N.,

2009; Bates, S., 2005; Bringewatt et al., 2010; Chorpita and Bernstein, 2011; DeRigne, L., 2010;

Edlefsen, M. and Baird, M., 1994; Hester et al., 2003; Kazdin et al., 1997; Keller et al., 2009;

Mahoney, G., 2007; McWilliam, R. et al., 1996; Owens et al., 2002; Peebles-Williams, W.,

2007; Rose et al., 2004; Saxe et al., 1988; Stormont, M., 2002; Tomasello et al., 2010).

Stormont, M. states the "earliest possible intervention is important for these types of children due

to their increased risk of maintaining and perhaps developing more severe behavior problems"

(2002, p127). Even though there are more services becoming available for children with mental

health needs, services are still being underused.

According to a 2002 study completed by Owens, Hoagwood, Horwitz, Philip, Poduska,

Kellam, & Ialongo, "approximately one third of parents who identified that their child had

mental health needs" report encountering barriers to care (Owens et. al, 2002, p735). This

research project will explore the main barriers for children and their families that may prevent

intervention or cause disruptions throughout the treatment process. This current study will

examine, through quantitative surveys, the perceptions of mental health professionals working

with families of young children in mental health service and the barriers they have previously or

currently encounter. The research question presented in this paper asks, "What are Mental Health

Professionals perspectives on the barriers preventing early intervention treatment and success for

children"?

LITERATURE REVIEW

Early intervention services are more available now than ever before, but still are underused and misunderstood by those who need services the most. "According to the National Survey of American Families, only 21% of children in need of mental health services actually receive them; the 70% that do not receive mental health care translates into 7.5 million children between the ages of 6 and 17 who are in need of mental health evaluation in the United States but do not receive it" (Bringewatt et al., 2010, p1292). In the following section early intervention programs, treatment barriers, and family barriers will be discussed to provide further information on the causes of underused services.

EARLY INTERVENTION PROGRAMS

The concept of early intervention began to form in the late 1960s with the passing of the Handicapped Children's Early Education Program. The program mandated that special education services need to be available for young children with disabilities (Mahoney, 2007). It wasn't until 1990 when the Individuals with Disabilities Education Act (IDEA) was first passed. IDEA made states accountable for individualized education and mental health programs for children. IDEA "mandated that states provide individual appropriate educational services to all children with disabilities…" and "… to establish comprehensive early intervention service systems for children" between birth to five (Mahoney, 2007, p3). IDEA has two separate parts for children under age five. Birth to age three is discussed in 'Part C', while age three to five is included in 'Part B' (Bates, 2004). "Part C is not only designed to improve developmental outcomes…but it also includes information and recommendations on how to work with families in a systemic and

comprehensive fashion" (Tomasello et al., 2010, p163). Part B relates to preschool and early education interventions.

The goal of early intervention is to "help minimize or prevent academic, social, emotional, and behavioral difficulties" (Bates, 2004; Edlefsen & Baird, 1994). Bates, S. (2004) conducted a study that focused on family prevention/intervention programs and found that the majority of children in the programs had behavioral or developmental disabilities. Developmental disabilities include severe, chronic disabilities that can present themselves at any time between birth and age 21 and the disability is expected to last for a person's lifetime. A study conducted by Hester, P. P., Baltodano, H. M., Gable, R. A., & Tonelson, S. W. (2003) gathered past and present research on children's early intervention programs and the different practices available. Hester et al. found that early intervention is the "most powerful course of action" to help prevent later behavior, emotional, and developmental issues (2003, p362). Children's behavior problems that are left untreated "typically multiply, intensify, and diversify over time… which may in turn put the child at an increased risk for academic difficulties, social isolation, and peer rejection" (Hester et al., 2003, p363). Conduct disorders present in adolescence and adulthood are established during the preschool developmental years (Stormont, 2002).

Younger children respond more quickly to treatment so treatment at an early age seems to be most effective (Edlefsen, 1994). "Earliest possible intervention is important for children at great risk for future behavior problems due to their increased risk of maintaining and perhaps developing more severe behavior problems" (Stormont, 2002, p127). "Younger children respond more quickly to treatment therefore treatment through intensive preschool programs makes therapeutic and financial sense" (Schmitz et al., 1996).

Schmitz, C. L., & Hilton, A. (1996) compiled information from a study with participants at three different preschool programs in different geographical locations. Results of the study found that the best and most effective services are those that assist the family and the child. If the therapeutic process is used, it helps re-establish family integrity and to promote a nurturing environment for the child (Schmitz et al., 1996; Edlefsen, 1994). During the therapeutic process it is crucial to acknowledge and take a family's values, customs, and beliefs into consideration. Parents play a crucial role in their child's needs being met. However, Axford, N. (2009) notes that a "met need" is not the same as "flourishing" and that what is sufficient in meeting their needs will not necessarily enhance their quality of life.

Schmitz et al. (1996) and Axford (2009) state that early intervention also helps lessen the stigma that is associated with mental health and behavioral issues in the classroom. Due to the isolation of preschool classrooms in schools or other facilities the children are receiving fewer stigmas from those around them (Schmitz et al., 1996). However, as the child ages, a non-mainstream school may be potentially stigmatizing due to the isolation of the child from their friends and communities (Axford, 2009). Successful day treatment programs contain small classrooms, case management, crisis intervention, family outreach, and therapies to foster social and emotional development (Schmitz et al, 1996).

Being able to involve the family in the change process provides access to a variety of community services. Using a variety of intervention approaches has been shown to greatly affect the outcomes of those in early intervention preschools (Schmitz et al., 1996). Children and families are engaged in a therapeutic process to provide skills, support, and resources to promote an emotionally nurturing environment for children (Edlefsen, 1994). Community health service organizations can provide an "environment where the child is accepted for who he or she can be

and can learn to do" (Edlefsen, 1994). "The long-term efficacy of the intervention process is dependent largely on its continuity and consistency across persons, across settings, and over time" (Hester et al. 2003, p363).

ACCESS BARRIERS

The term barriers can have many different meanings depending on the subject matter. For this paper, barriers will be defined as "factors that increase risks for mental health disorders, worsen their course or impact, or lead to inefficient use of health care or societal resources" (Knapp et al., 2006, p158). Access barriers take place at multiple levels: financial, structural, and personal/family barriers are the most researched. The family's current or previous treatment experiences can also be a barrier to service (Berger & Umaschi, 2011). For the growing number of children who are in need of service, a study completed by Knapp, M., Funk, M., Curran, C., Prince, M., Grigg, M., & McDaid, D. (2006) found that "there are not enough resources available in the right places or at the right time, or allocated appropriately, to meet the mental health needs of populations" (p158).

A study completed by Tomasello, N. M., Manning, A. R., & Dulmus, C. N. (2010) found that many families that have children with severe and/or multiple disabilities have a greater chance of experiencing immense physical and psychological stress. Tomasello et al. note that previous research has also shown that family members of a child with a disability have a higher risk of developing depression and reduced quality of life. According to review of literature by Saxe, L., Cross, T., and Silverman, N. (1988), "making appropriate treatment available is the essential problem" (1988, p 803). Saxe et al. found that with children dealing with emotional and behavior problems, appropriate treatment can come in a variety of ways. However, it needs

to address conditions within the family, the community as well as individual child characteristics (Saxe et al., 1988).

Kazdin, A. E., Holland, L., Crowley, M., & Breton, S. (1997) conducted a study with 260 children in an outpatient treatment clinic to examine the barriers families and children face during the participation and completion of therapy. Kazdin et al. states that "among those who enter treatment, 40-60% leave prematurely and against the advice of treatment providers" (1997, p1051). Clients who leave treatment early or do not receive treatment at all may face many barriers in gaining access to service and/or to keep program access throughout treatment. "Two reasons chosen most frequently were "cost too much" and "health plan problem" (DeRigne, 2010, p11). Barriers can include, but are not limited to, cost of treatment, insurances, programming service, family life, poverty, and cultural beliefs. The most common barriers are discussed further below.

Knowledge of programming. When children are displaying concerning behaviors or a lack of development, they initially may go to their medical doctor. It is important for physicians to be knowledgeable about behavior and development delays and the services that can assist the child and family. Often times, however, parents are not given information about services (child or family) that are available. In a literature study by Bringewatt and Gershoff (2010), the researchers looked at the unmet needs of children, the history of children's mental health policies and the types of services available for children. Bringewatt and Gershoff found that advocacy groups blamed states and managed care services for not properly informing parents about the services that their children were eligible for and were available to them (2010). It is important that services are properly coordinated between professionals to get the most accurate information about the child and what treatment will be most effective.

Referrals. A child can be referred to a mental health service by a variety of people –
parents, social workers, physicians, and teachers. Sayal (2006) compiled information about the
access to services while looking at the parental perception of the child's problems. Parental
acknowledgement of the child's issues was noted as the first barrier to overcome when looking
for and outside program for assistance. Child and family factors are important during the referral
process (Sayal, 2005). It is important to complete a full assessment of the child, the family, and
the child's living environment to determine the need for service and which service may be the
most useful.

Keller and Fox (2009) studied 58 toddlers that were referred to a mental health clinic that
specifically addressed the problems behaviors the children were showing. The study showed that
the children who are most likely to be referred are those who exhibit temper tantrums,
aggression, oppositional behavior, self-injury, and hyperactivity. If the previous issues are
discussed with a physician, the physician may not know the treatments or interventions available
and why the behaviors are being displayed. Due to a young child spending much of their time in
preschool or daycare settings, educational staff and daycare staff need to have an increased
knowledge and understanding about mental health needs and services. Educational instructors
are sometimes the first person able to identify needs of a child. A Stormont review in 2002,
examined variety of specific treatments available for children and families. School settings need
the support to be able to identify child problems and to have the knowledge to make proper
referrals. Whether it's a teacher or a physician that indentified the need for service, it is
important to recommend and refer the family to research-based interventions (Stormont, 2002).

Referrals are many times required in order to gain access to mental health services and
for them to be covered by insurance. It is important for the reason for referral to be explained to

the parents and what services they are referring the child to. Parents need to understand the

referral process and how mental health services can assist their child with behavior and/or

educational difficulties.

   Cost of service. In a study completed by Schmitz et al. (1996) and DeRigne (2010) the

average cost of mental health treatment per child per year is around $15,000 (Schmitz et al.,

1996). Even those parents who have a high income can be "confronted with treatment costs that

are unaffordable" (DeRigne, 2010, p7). A highly successful service or program will be of no

value to children if people are not able to afford it. For families that are not eligible for public

insurance programs, mental health services can be almost impossible to afford. Even those with

insurance, out-of-pocket expenses such as transportation can lead to great financial burden

(Bringewatt et al., 2010). DeRigne (2010) found that, "15.6 percent of parents of insured

children reported that the reason for unmet need was that services cost too much" (p 11).

   Insurance. Insurance companies, public and private, are providing plans with a variety of

mental health coverage. However, it is estimated that nine million children are uninsured

(Bringewatt et al., 2010). A mental health plan for children can be very limited and have many

restrictions. Having insurance coverage "neither equals nor guarantees service accessibility"

(Manning, 2009, p48). Families having any type of insurance can greatly assist a family with

payment for treatment services. Yet, even with insurance, treatment can be ineffective and

disrupted due to barriers within the insurance companies.

   When deciding on treatment plans, professionals may come in conflict with choosing

interventions that would be reimbursed by insurance companies rather than the services the

family or child actually needs. Due to policies and program requirements constantly changing, a

diagnosis may be required to be provided for the child to receive mental health services.

However, many insurance companies do not provide assistance for psychosocial mental health treatments (Bringewatt et al., 2010).

Due to family therapy not covered under Part C of IDEA, professionals may only give information about child services and may not offer information about family services that may perhaps be needed (Tomasello et al., 2010). If families have a change in insurance eligibility status during treatment, services may be interrupted causing a delay in programming and possibly a set-back for the child and/or family. Insurances may also place a "cap" on how many sessions a person is eligible for given their diagnoses (McWilliam, 1996).

Transportation. Transportation may be covered by the family's insurance plan. In a study by Manning, A. (2009) children's mental health in the United States was reviewed. Manning notes, "studies have previously shown that the main reason a child does not receive physical or mental health services is parental scheduling and transportation issues" (2009, p48-49). Transportation services are usually not covered under private insurance companies. Many times community mental health services are not provided in the neighborhoods that need them the most, only adding to accessibility issues. If a child is not able to access service, those services are no use to them. The proper transportation, specifically for toddlers and preschool aged children, is vital in providing children's mental health service. Referring back to the cost of programming, many parents work and are not able or cannot afford time/money to transport their child. It is a great benefit to be able to have transportation covered and trust that your child will get to the program safely. Unfortunately, it's one of the most common barriers to treatment.

Program/Organization Restrictions. Once a client is referred to a mental health service, the client must meet the programs requirements as well. Intervention effectiveness may be applicable only to those participants who meet the rigid criteria for inclusion in a particular

intervention (Hester et al., 2003). Many organizations that work one-on-one with individuals are not mandated to require family care (Rose et al., 2004). Working with the individual may be effective, but working with the entire family unit may increase treatment effectiveness. Organization policies and beliefs may also come in to conflict with the therapists' idea of the ideal treatment or intervention for a client. The therapist and family need to decide together on what treatment will be most effective and where to receive that treatment.

Limited providers. Like many human service organizations, mental health services are going through budget cuts and have to do more with fewer funds (McWilliam, 1996). Providers are getting fewer, yet caseloads are getting larger. Some children are receiving fewer services than they need due to therapists' case loads and limited time. Some services and evaluations are not able to be provided within an acceptable time period due to the therapists' schedules. Providers can also have a frequent turnover rate causing instability within treatment (McWilliam, 1996). Within services there may be a lack of pediatric specialists and programs. Services may be less available in rural or low-income areas where children do not have easy access to the services they need.

Time of programming. In 2004, Rose, Mallinson, and Walton – Moss explored focus groups in which seventy-eight individuals took part in to discuss the multiple barriers they may encounter when seeking psychiatric services. Rose et al. found that many barriers come from the lack of support and availability of services. Scheduling appointments for intakes and evaluations can cause complications before services even begin. Program schedules and parent schedules are often in conflict. For a program to be effective, appointments must be available at a variety of times so they are able to fit with the needs of their clients and families. Parents may not be able to continuously take time off for appointments and meetings due to work responsibilities. Parents

may also have to arrange child care for other children in the family. This only adds to the stress and financial burden parents face with children needing mental health services.

FAMILY BARRIERS

Children are many times not able to tell their parent or other adults what they are feeling or what they feel is bothering them. Children are unable to decide for themselves what to do to fix problems, therefore relying on their parents and adults to help them when they are facing difficulties. Many obstacles can come in to play when a parent is coming to terms with a child's disability and attempting to find affordable, effective treatment.

Parent Acceptance and Engagement. A child's home is the most influential environment during the early stages of life. Therefore, parents are seen as crucial members especially during therapy. It is important that parents acknowledge their child's mental health needs and are willing to seek the help that their child needs in order to develop. Parents also have to acknowledge what expectations are involved with treatment. It remains a substantial limitation for parents realizing interventions' wide range of benefits (Berger & Umaschi, 2011).

Low-income families may not realize when their child may be in need of mental health services due to possible parental mental illness and other financial, environmental, or housing stresses (Edlefsen, 1994). Other parental barriers can include suspicions of agencies, personal dysfunction, intellectual limitations, substance abuse or a sense of hopelessness (Edlefsen, 1994). Parental perception of a child's problems is seen as the key first step in the help-seeking process. Less than half of parents of a child with a disorder perceive a problem (Sayal, 2005).

According to a 2011 parent focus group study completed by Berger & Umaschi, after discovering a child's need for mental health services, parents may feel "demoralized and helpless

to influence their child's future" and may not perceive treatment as relevant or helpful (p6).

Families may not be ready for the complex demands of skill-based behavior strategies that may

come with child and family treatments. Features of a child that are not within a parent's control

may prevent parents appreciating the real value of the treatment that is available.

Parents must also be ready to invest time and other resources necessary for active

participation in their child's treatment. "Families often require financial, social, psychological,

and other support services" that may not be readily and quickly accessible (Tomasello et al.,

2010, p165). For those families who lack resources to complete day-to-day tasks, making a

commitment to attend daily treatment appointments may be overwhelming. Those children who

are in most in need of services may be least likely to attend due to scheduling complications.

Parents may "feel challenged and/or overwhelmed to engage in treatment when they

themselves are under great stress or perhaps experiencing their own mental health problems"

(Berger & Umaschi, 2011, p6). Parent hopelessness and pessimism that can be associated with

stress and depression may lower expectations in effective treatment (Berger & Umaschi, 2011).

Divorce and family unemployment was also associated as a barrier to mental health problems

and services (Owens et al., 2002).

Poverty. "Poverty is one of the major risk factors identified as increasing the vulnerability

of children and families" (Schmitz et al., 1996). Children who live in poverty situations are more

likely to suffer from mental illness. While poverty itself does not have a direct effect on mental

health, the indirect effects are numerous. "Children in low-income families are at increased risk

of being exposed to community and interpersonal violence, and such exposure of violence is a

predictor of children's mental health outcomes" (Bringewatt et al., 2010, p1292). Those children

with ongoing violence may develop a perception that they are constantly in danger which may

increase fear and anxiety. Certain children may also be at greater risk for behavior problems due to poverty (Stormont, 2002). "Preschool children from low-income families experience more socio-psychological stressors and enter school with "fewer intellectual, social, and emotional school-readiness skills" than other children" (Schmitz et al, 1996, p3; Edlefsen & Baird, 1994, p567).

Parents that are living in poverty are under a great deal of financial and emotional stress. It can "affect their parenting behaviors, which in turn can affect the mental health of their children" (Bringewatt et al., 2010, p1292). Being overwhelmed by facing the day-to-day difficulties can drain the parents' energy and can limit the amount of support they are able to give to their children. Nearly 22% of African American families are living below the poverty level, and many might find addressing mental health needs a low priority when facing more immediate needs such as food and housing (Hunt-Harrison & Ellison, 2006).

Parents in poverty may also have their own mental health issues which can have an effect on their child's mental health. Poverty may prevent those people with long-term mental health problems and/or their families from being able to afford new medications or certain treatments they may be helpful (Knapp et al., 2006).

Cultural beliefs. Cultural differences can be an enormous barrier to receiving mental health treatment. Different racial and ethnic groups have differing perspectives on when services are appropriate. "Not all cultures value the pursuit of insight, truth, 'getting ahead', or sharing problems or feelings" (*Edlefsen as quoted by McGolderick (1982), 1994).* Mental health professionals must understand the importance of religious and cultural differences between clients and their families.

In a 2006 study completed by Hunt-Harrison, T. & Ellison, T. found that "African-American youth have been found to have a mental disorder prevalence of 21.9%, but only 3.2% of that group actually used specialty mental health services in a three-month period" (Hunt-Harrison & Ellison, 2006, p27). African Americans children have been shown to be treated more for behavior problems rather than a mental illness (Rose et al., 2004). Due to unmet needs, African American parents may not seek further assistance or be suspicious of other helping agencies.

In Hmong culture, for example, they find it a weakness of character to express feelings of unhappiness and grief. They believe that disabilities or health issues stem from disgrace to an ancestor or a sort of payback to an unacceptable behavior or action. Within the Hmong language, there are no accurate terms to describe mental health issues. Hmong does not easily translate in to English so meanings may often be lost during translation. Historically, Hmong culture did not have a profession of a mental health counselor or therapist so it is a new and somewhat foreign idea for them to get behind. It is important for the clinician to be able to clearly communicate the need for service, what the service will be providing, and how it may help their child.

From the two brief examples provided above from previous studies, it is clear that professionals need to take cultural beliefs into consideration when working with minority clients. It is important to understand their values and what is acceptable for treatment and during the treatment process.

Stigma. Stigma is a term that is often associated with mental illness. Unfortunately, the stigmas associated with mental health may result in a denial of problems and reluctance to use available services (Owens et al., 2002). Stigmas are stereotypes that the general public learns through different social groups. Parents may believe that professionals will blame them for their

child's mental health issues. Parents and/or children may be stigmatized by peers, which may be greater among those of color whom already suffer from discrimination.

While most stigmas are considered to be 'public-stigma', Corrigan explains that there is also a self-stigma. Public stigmas are targeted towards a group of people, and can lead to a group avoiding a label to prevent stigma. Public stigma also has an influence on the criminal justice system and the health care system.

Stigma is also observed in the general health care system. Some families may also have distrust in health care providers limiting services that are sought out. Those with a mental illness are less likely to benefit from the available physical health care than those without a mental illness (Corrigan, 2004).   Highly mobile parents may not be able to build a strong relationship with their child's doctor due to constantly changing locations. This may lead to parent's reluctance in discussing their child's mental health issues or concerns.

An individual may self-stigmatize themselves by believing the stereotypes and stigmas already set in place by the community. Self-stigma may have a harmful effect on self-esteem, self-efficacy and self-confidence. Self-stigma can have influence on a person's goals and quality of life. Self-stigma may prevent someone from seeking and attending treatment or evening applying for employment (Corrigan, 2004).

Stigma is not culturally specific. However, there are differences between cultures and how stigma impacts them. In the African American culture, "stigma and lack of knowledge regarding the significance of mental healthcare likely solidify negative views" of mental health services (Hunt-Harrison & Ellison, 2006, p27). The stigma that many times goes along with mental illness may be added on top of the stigma that a certain culture group already receives.

Trying to overcome multiple layers of stigma may be very difficult, especially if you have other

barrier and stressors to overcome.

   Lack of family support before, during, and/or after treatment. Parents that have

children with a mental illness may become isolated from friends and families due to the lack of

understanding and knowledge of mental illness. With a lack of outside support, families often

turn to the mental health professionals because others may not understand what they are going

through. Professional support is needed to help overcome the stigma that comes along with

mental illness. However, according to a study by Biegal, as cited by Rose, et al. "investigators

have documented that families do not receive adequate support from professionals" (2004, p40).

   Some of the clients that are being served may not even have a support system in place.

Due to recent increased immigration around the country, families may get separated from each

other. More families are being served that have very little family contact and/or have a support

group available to them. Professionals need to be aware of the variety of stressors on the family

before, during, and even after treatment.

METHODOLOGY

The present exploratory study focuses on the variety of barriers that families and children face when attempting to access mental health services. Services are widely available yet highly unused by those who need them most. Therefore, the quantitative survey was designed to explore the topics of treatment barriers, program barriers, and family barriers from the views of mental health professionals. This research project asks the question "What are Mental Health Professionals perspectives on the barriers preventing early intervention treatment and success for children"?

SAMPLE

The sample for this study was 29 individuals. The participants are professionals that work with a children mental health program in the Minneapolis/St. Paul area. Each participant holds a job title of Social Worker, Case Manager, Intake/Assessment, or Mental Health Professional. The target sample is employed by a center that serves children mental health issues as well as children with Autism. The center works with a day treatment program as well as out-patient clients.

A non-probability, purposive sample was conducted to recruit participants. E-mails were sent out to participants to inform them about the study and why their participation was needed. This researcher distributed surveys in March 2012 after the proposal was approved by the University of St. Thomas IRB. The data was analyzed in April 2012.

DATA COLLECTION

After the Fraser IRB approved the proposed study, e-mails were sent out using the existing company e-mail program to possible participants to inform them about the research study. Lists of participants were gathered through the employer e-mail contact list based on the job titles listed above. The possible participants received an informational letter (see *Appendix A)* about what the survey entails and why their time is appreciated in helping gather research in this area of study.

Surveys were delivered via e-mail. A link was provided to complete the survey. To enforce confidentiality, the survey was on-line and submitted anonymously. By completing the survey, the participant essentially signed consent. All survey answers were kept confidential and anonymous. Participants were given the researcher's contact information if they had questions about the study or the survey presented. Participants were not given any incentive for doing this study.

MEASUREMENT

The measurement tool that was used for this study was a 9-question multiple choice and rank scale survey. The questions were created by this researcher based on past and current research completed on mental health services. The overall themes of the questions were focused on family barriers of treatment, program barriers, and overall service barriers of mental health treatment. The survey will take approximately 5 minutes to complete.

DATA ANALYSIS

      After the surveys were returned, answers were analyzed using the survey website software. Descriptive statistics will be in the form of Likert and rank scales to determine the variety of barriers and their effect on treatment.

PROTECTION OF HUMAN SUBJECTS

      Significant efforts were made to protect confidentiality and anonymity of all participants. No documents contain personal, identifying information about the participant. There were no risks in participating in this study. The e-mail provided information about the study and provided consent information. By submitting the survey, the participant gave their consent to participate in the study.

FINDINGS

Twenty-nine total participants were surveyed about the barriers families and children face while accessing mental health treatment. The majority of participants were mental health practitioners. To understand the participant's backgrounds refer to Table 1.

Table 1: Participant's Employment Background
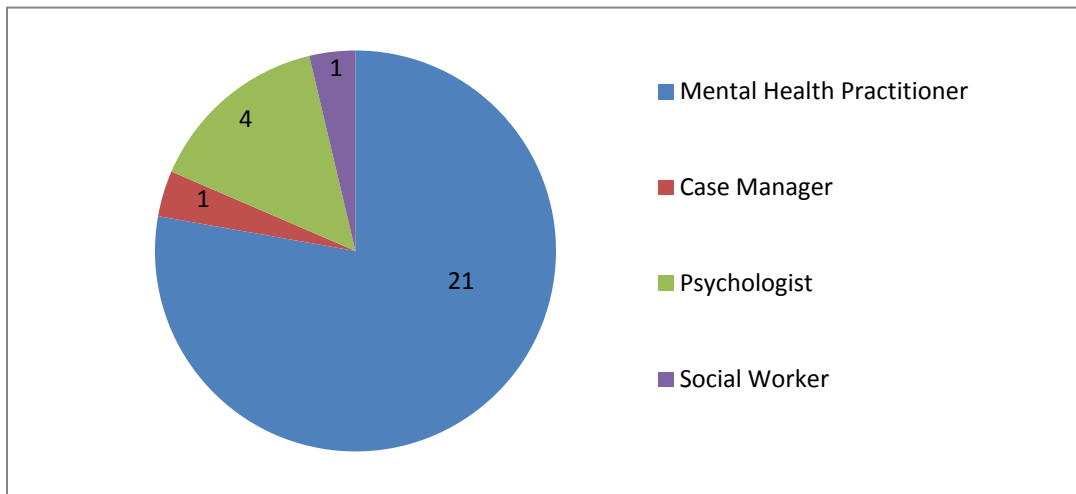
When comparing data across the board, it was noted that there were no significant associations between variables. Chi-square tests were run to find any significance between employment positions with each barrier; child's race with each barrier; and number of years worked in the field with each barrier. After analyzing results, no significant associations were found.

ACCESS BARRIERS

Participants were asked to rate each access barrier with a 4 point scale: 'Not a barrier' to 'Major Barrier'. For each barrier there was a 100% response rate. All respondents rated "scheduling difficulties" as a barrier. 28 (96.55%) participants rated "lack of program

knowledge" and "transportation" as a barrier. The remainder of the barriers were rated in the

following order (refer to Table 2): insurance difficulties (n=27, 93.10%), program

restrictions/requirements (n=26, 89.66%), referral difficulties (n=25, 86.21%), cost (n=23,

79.31%), culturally insensitive programming (n=21, 72.41%), and lastly, lack of professional

support (n=16, 55.17%).

Table 2: Access Barriers Histogram
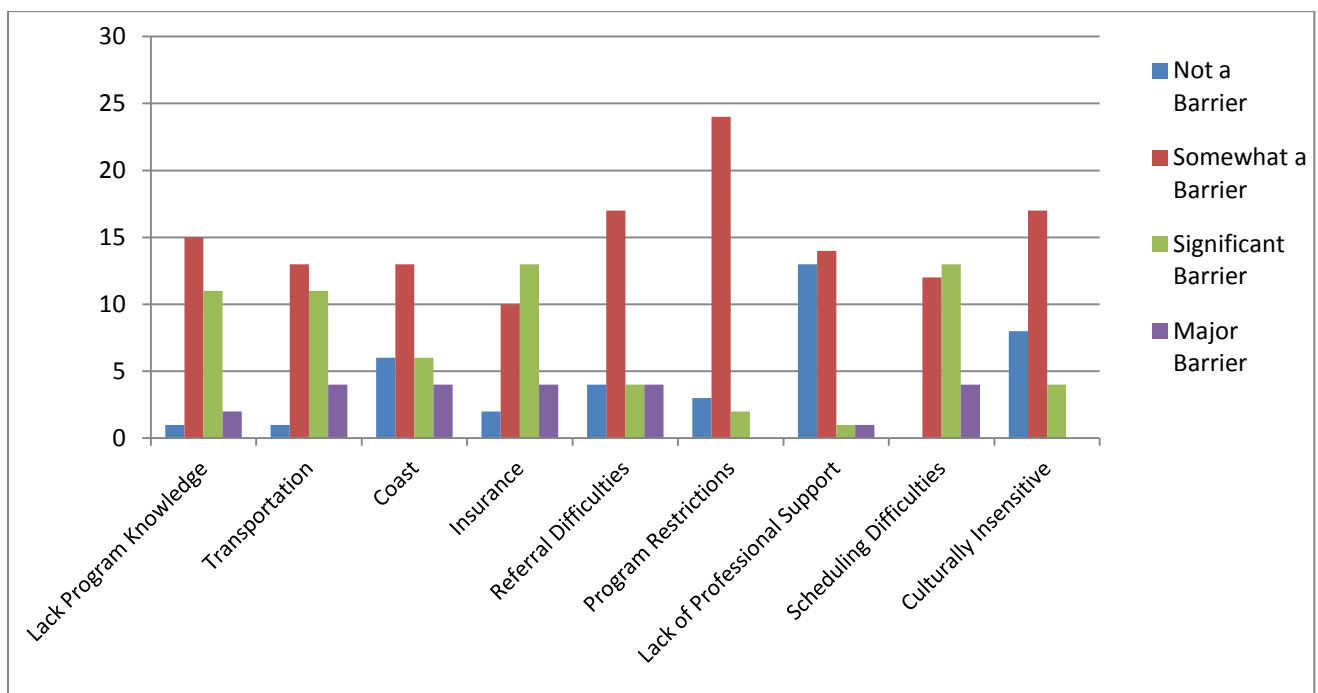
Participants were then asked to rank the top 3 treatment barriers they encounter with

clients (refer to Tables 3, 4, 5). 19 (70.99%) participants ranked scheduling difficulties as the

most encountered barrier. 15 (54.78%) participants ranked insurance coverage, followed by

transportation (n=14, 51.63%).

The first ranked barriers are displayed in Table 3. The most ranked barrier was insurance coverage by 8 participants (28.57%) followed by transportation (n=6, 21.43%) and scheduling difficulties (n=5, 17.86%).

Table 3: First Ranked Access Barriers
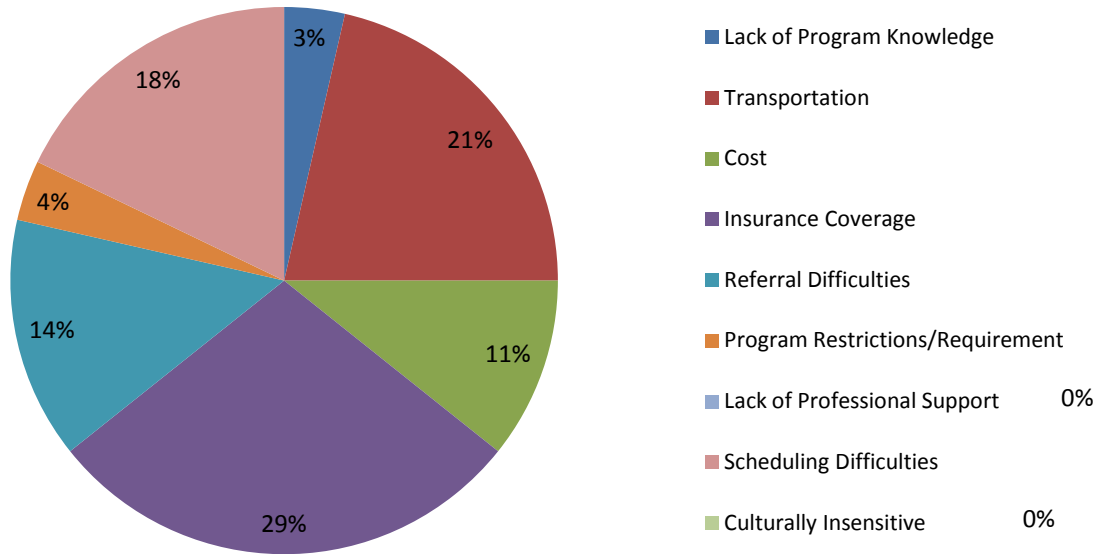
The barriers that were ranked second are displayed in Table 4. The top ranked barrier in this ranking breakdown was insurance coverage and scheduling difficulties by 5 (18.52%) participants. Transportation and cost followed with 4 (14.81%) participants.

Table 4: Second Ranked Access Barrier
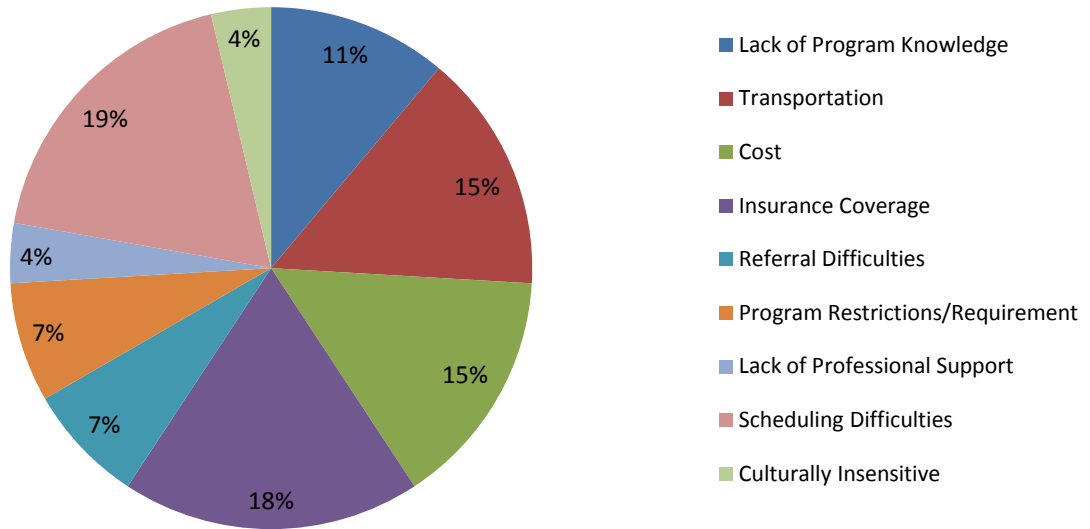
The barriers that were ranked third are displayed in Table 5. The top barrier in this ranking

breakdown was scheduling difficulties with 9 participants (34.62%), followed by cost with 5

participants (19.23%). As seen in other results, culturally insensitive and lack of professional

barriers were minimally ranked, only ranked by 1 (3.70%) participant. Program restrictions were

also minimally ranked.

Table 5: Third Ranked Access Barrier
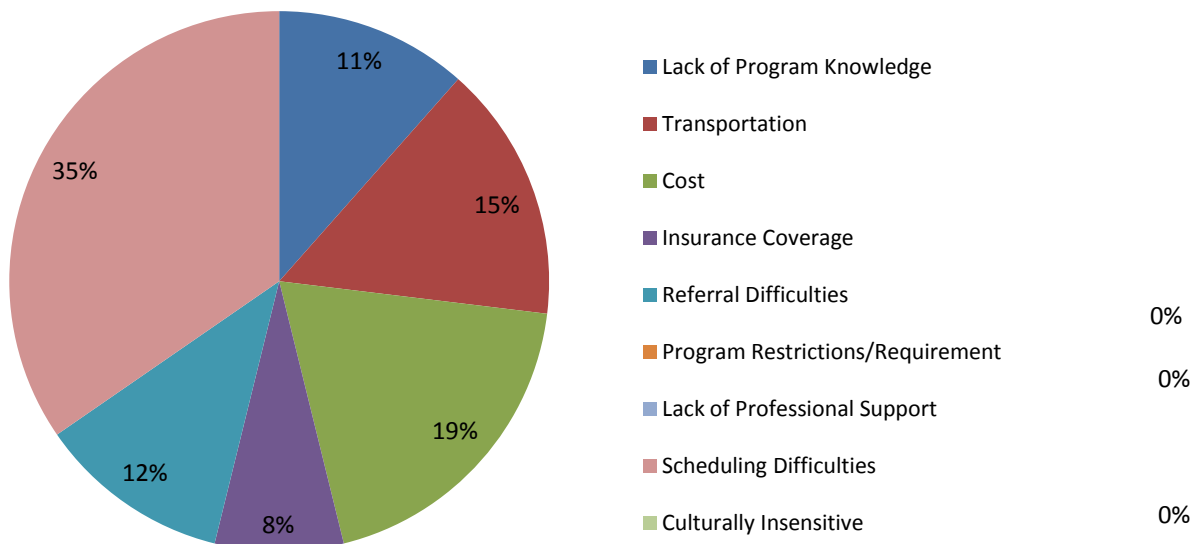
FAMILY BARRIERS

Participants were asked to rate each family barrier with a 4 point scale: 'Not a barrier' to 'Major Barrier'. For each barrier there was a 100% response rate. All respondents rated "parental engagement/involvement" as a barrier. 28 (96.55%) participants rated "family support" and "transportation" as a barrier. The remainder of the barriers were rated in the following order (refer to Table 6): poverty (n=27, 93.10%), stigma (n=26, 89.66%), and family acceptance and cultural barriers (n=5, 86.21 %).

Table 6: Family Barriers Histogram
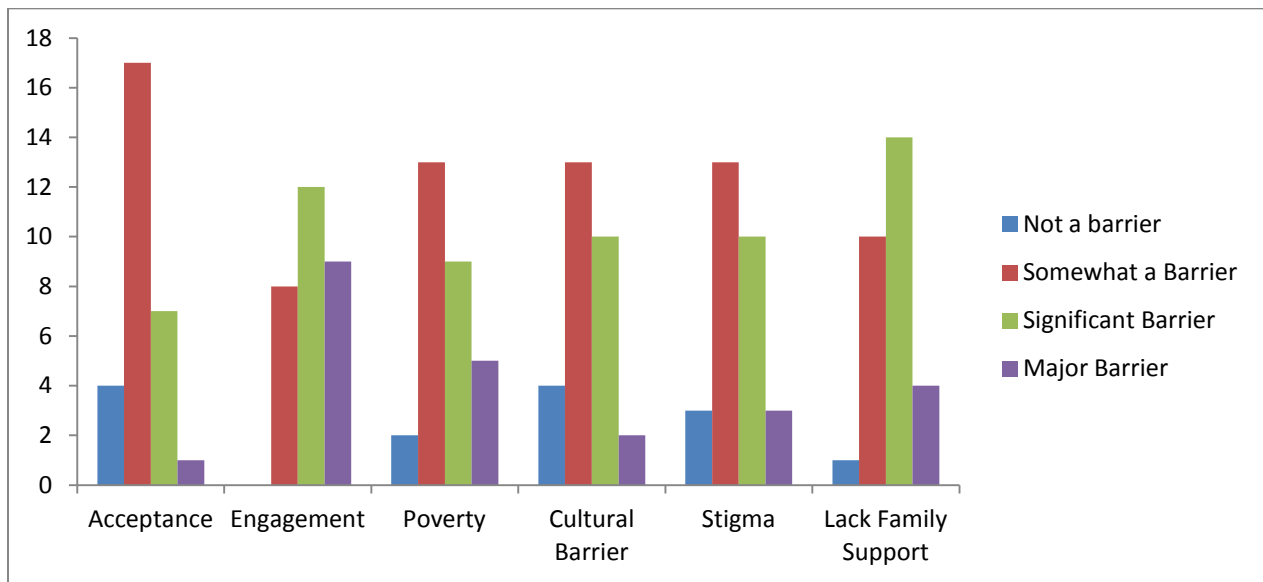
Participants were then asked to rank the top 3 family barriers they encounter with clients (refer to Table 7,8,9). Overall, looking at all family barriers, 26 (64.64%) participants ranked parental engagement as the most encountered barrier. 16 (58.93%) participants ranked lack of family support, followed by family acceptance 11 (42.86%) participants.

The highest ranked first encountered barrier (refer to Table 7) was family participation by 18 participants (64.29%) followed by poverty 1 (14.29%) participant.

Table 7: First Ranked Family Barrier
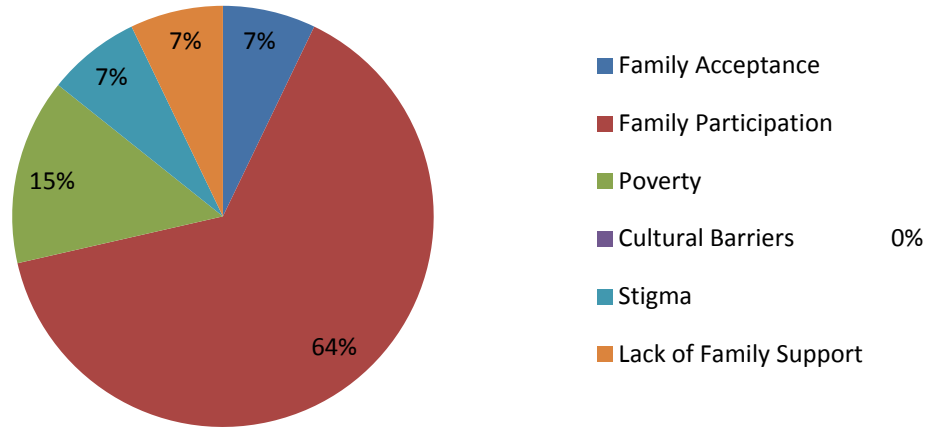
The barriers that were ranked second are displayed in Table 8. The top ranked barrier in this ranking breakdown was lack of family support by 11 (39.29%) participants followed by family participation by 5 (17.86%) participants.

Table 8: Second Ranked Family Barrier
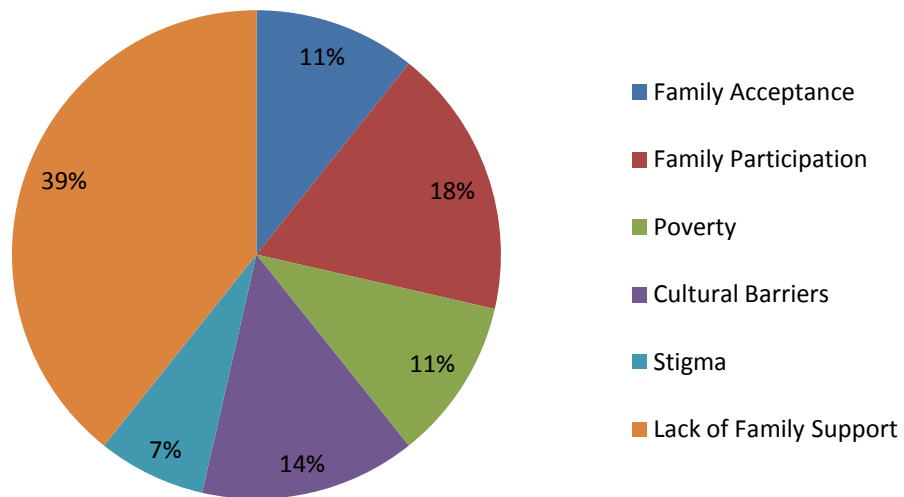
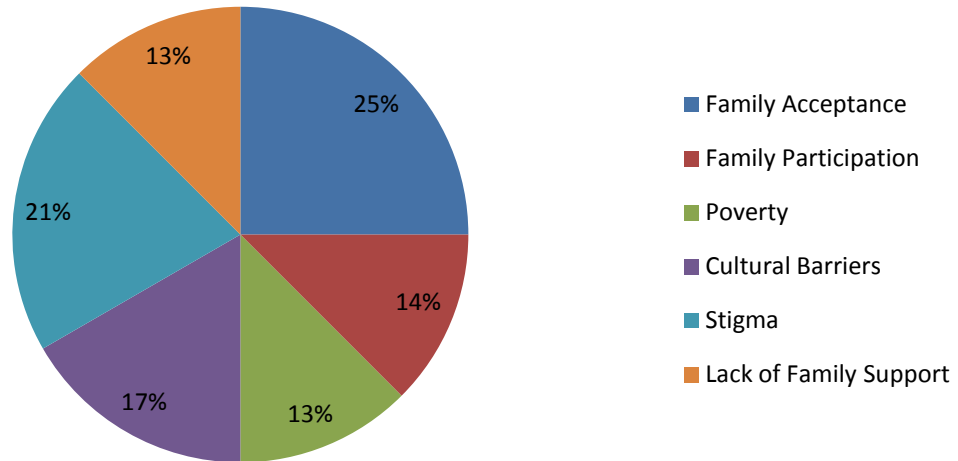The barriers that were ranked third are displayed in Table 9. The top ranked barrier in this ranking breakdown was family acceptance by 6 (25%) participants followed by stigma by 5 (20.83%) participants.

Table 9: Third Ranked Family Barrier

DISCUSSION

After reviewing the results from the survey, the most noted access barriers were those of insurance and family participation. They were also frequently reported within the current literature. In the next section, the current literature will be compared with the current findings, limitations of the study will be discussed as will future impact to social work policy, research, and education.

CURRENT LITERATURE WITH CURRENT FINDINGS

Within the current literature, there are few studies from the professional's point of view. It is important that research looks at both professional's views and individual's views of barriers to see if they match. If a professional thinks something is a barrier but the individual does not, the professional is leaving other barriers unidentified and is unable to address them.

The current literature identifies many barriers that prevent children and families from accessing services. Lack of program knowledge, transportation, cost, insurance coverage, referral difficulties, and culturally insensitive programs were only a few discussed. Family barriers such as cultural stigma, parent acceptance and poverty can also prevent utilizing services.

The survey results report that insurance coverage, program restrictions and referral difficulties were the three most common access barriers according to the professionals. The survey also reports that family engagement and participation, lack of family support, and family acceptance were the three most common family barriers.

It is estimated that nine million children are uninsured (Bringewatt et al., 2010). A mental health plan for children can be very limited and have many restrictions. Having insurance coverage "neither equals nor guarantees service accessibility" (Manning, 2009, p48). Due to the

increase in childhood poverty and other risk factors, children and their families are in great need

of our assistance to make their future as successful as possible. "Children in low-income families

are at increased risk of being exposed to community and interpersonal violence, and such

exposure of violence is a predictor of children's mental health outcomes" (Bringewatt et al.,

2010, p1292).

Both the literature and the survey results noted that getting parents involved was a barrier

to treatment. Within the current survey results, parent involvement was rated a major barrier by

9 (31%) participants with the next major barrier of poverty with 5 (17.2%) participants. Within

the literature, Edlefsen et al. stated "…the inability of parents to show interest or participate in

their child's educational experience has become increasingly apparent" (1994, p567).

In order for the children to benefit from treatment, parents need to be more involved

during the treatment process and work with their child in the home as well. Parents must also be

ready to invest time and other resources necessary for active participation in their child's

treatment. "Families often require financial, social, psychological, and other support services"

that may not be readily and quickly accessible (Tomasello et al., 2010, p165).

LIMITATIONS

With 29 participants, the results are not able to be generalized to a larger population but

are helpful in identifying the barriers this participating agency and the families it serves face in

order to receive mental health treatment. While twenty-nine participants responded to the survey,

many opinions did not get received. At this agency, most of the employees are Caucasian

females with a Bachelors or Masters degree. While the agency serves a variety of races,

backgrounds and families, they may not have been properly represented in these results. With a

limited number of participants, the findings are not able to be generalized to a greater population.

IMPACT TO SOCIAL WORK POLICY AND PRACTICE

When developing new policies, or adjusting the old ones, it is important for professionals

to look at mental health and education policies that are currently in place and/or to look at

policies that have passed and failed previously. If we have ineffective policies, children will not

be able to achieve their possible success. With the diagnosis of mental health disorders

increasing, it is important to have services available to serve those in need. It is also crucial that

the education system is able to address the issues and take action that best suits the child's

need(s). Policies must take into account a child's family and community in which they come

from (Saxe et. al., 1988). It is crucial to have policies that will assist families and their children

to receive the help that they need.

Currently, although policies mandate services for children that have emotional and

behavioral problems, needs are not being met accordingly (Schmitz et al., 1996). Knowing that a

child needs an identified service yet the school policy prevents the service from being carried

out, is not in the child's best interest. Education policies need to look at the child, the educators,

the services, and the school environment to make sure they are able to do all they can to help a

student succeed.

When families are involved in their child's treatment, past research and the current

findings show that it greatly increases the child's success and improvement rate. Finding

effective ways for parents to become involved is a key to helping their child succeed.

Acknowledging the barriers families face and working with agencies and government to assist in decreasing barriers or providing services to help overcome those barriers is important. It is also important that an agency working with a diverse population make their service available to all the clients their service is targeted to. Programs need to be most focused on the needs of the families that are most effected by their child's psychosocial problems (Owens et al., 2002).

IMPACT TO EDUCATION AND FUTURE RESEARCH

College courses specifically focused on children and families is something to look in to for future programs. Very few classes focus specifically on traumatized children and how to effectively work with them as individuals as well as the family unit. Learning about the cultures in the area and how mental health is different in each culture is also important to learn about. Classes continuously talk about being culturally competent, but rarely discuss how the different cultures view mental health and assistance they may receive by a social worker.

Continuing education should be provided for employees that work with a diverse population. Each culture may have a separate belief about mental health and must be considered when working with the family and individual. Continuing education for current resources throughout the community is important so that clinicians are giving the most up-to-date services that will meet their current needs.

Supervision for clinicians is also important. Working with young children with severe emotional and behavior issues can be very difficult work. Having a place to receive feedback and talk about the struggles an employee is having will help decrease the risk of burn-out and assist them in becoming a stronger and more confident clinician.

There is a great need to further research the topic of early childhood mental health interventions. There is very little research done on children of preschool age and effective treatments. Previous research and current findings show, however, early intervention is the key and there is a great need for services. If providers are able to work with children at an early age, the more likely the child will have later success. Research must be completed to know what interventions and techniques are most effective on young children so we can build policies and services around their needs.

CONCLUSION

Both the literature and the survey participants confirm how important early intervention is yet how there are still many barriers that can prevent effective treatment. Edlefsen et al. (1994) also suggested that there is a belief that early intervention can possibly help minimize or prevent either secondary or more serious emotional, social, and academic problems.

The number of children showing emotional and behavioral disturbances is growing quickly and many children are still not being served. Early intervention is crucial in teaching kids how to manage behaviors so they can succeed throughout life. If people take a look at our current policies, programs and conduct further research, services will be able to provide for those children in need and will have a chance to succeed.

REFERENCES

Axford, N. (2009). Developing congruent children's services to improve child well-being. *Child & Family Social Work*, 14(1), 35-35. doi:10.1111/j.1365-2206.2008.00579.x

Bates, S. L. (2005). Evidence-based family-school interventions with preschool children. *School Psychology Quarterly*, 20(4), 352-370. doi:10.1521/scpq.2005.20.4.352

Berger, R. H., & Umaschi, S. S. (2011). Parent engagement in child and family treatment: Considering the barriers. Wiley Periodicals, Inc.

Bringewatt, E. H., & Gershoff, E. T. (2010). Falling through the cracks: Gaps and barriers in the mental health system for America's disadvantaged children. *Children and Youth Services Review*, 32(10), 1291-1299. doi:10.1016/j.childyouth.2010.04.021

Cooper, J.L., Masi, R. and Vick, J. (2009, August).*Social-emotional Development in Early Childhood: What Every Policymaker Should Know*. Retrieved October 2011 from National Center for Children in Poverty: http://www.nccp.org/publications/pub_882.html.

Corrigan, P. (2004). How Stigma Interferes with Mental Health Care. *American Psychologist*, 59(7), 614-622.

DeRigne, L. (2010). What are the parent-reported reasons for unmet mental health needs in children? *Health & Social Work*, 35(1), 7-15.

Edlefsen, M., & Baird, M. (1994). Making it work: Preventive mental health care for disadvantaged preschoolers. *Social Work*, 39(5), 566.

Hester, P. P., Baltodano, H. M., Gable, R. A., Tonelson, S. W., & Hendrickson, J. M. (2003). Early intervention with children at risk of emotional/behavioral disorders: A critical examination of research methodology and practices. *Education & Treatment of Children*, 26(4), 362.

Hunt-Harrison, T., & Ellison, T. (2006). Confronting barriers. *Behavioral Healthcare*, 26(9), 27.

Kazdin, A. E., Holland, L., Crowley, M., & Breton, S. (1997). Barriers to treatment participation

scale: Evaluation and validation in the context of child outpatient treatment. Journal of

Child Psychology and Psychiatry, and Allied Disciplines, 38(8), 1051-1062.

doi:10.1111/j.1469-7610.1997.tb01621.x

Keller, K. M., & Fox, R. A. (2009). Toddlers with developmental delays and challenging

behaviors. Early Child Development and Care, 179(1), 87-92.

doi:10.1080/03004430600987126

Knapp, M., Funk, M., Curran, C., Prince, M., Grigg, M., & McDaid, D. (2006). Economic

barriers to better mental health practice and policy. Health Policy and Planning, 21(3),

157.

Mahoney, G. (2007). Social work and early intervention. Children & Schools, 29(1), 3.

Manning, A. R. (2009). Bridging the gap from availability to accessibility: Providing health and

mental health services in schools. Journal of Evidence - Based Social Work, 6(1), 40-57.

doi:10.1080/15433710802633411

McWilliam, R. A., Harville, K., & Young, H. J. (1996). Therapy services in early intervention:

Current status, barriers, and recommendations. Topics in Early Childhood Special

Education, 16(3), 348-374. doi:10.1177/027112149601600306

Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska, J. M., Kellam, S. G., &

Ialongo, N. S. (2002). Barriers to children's mental health services. Journal of the

American Academy of Child and Adolescent Psychiatry, 41(6), 731-738.

doi:10.1097/00004583-200206000-00013

Peebles-Wilkins, W. (2007). Why early intervention? Children & Schools, 29(1), 45.

Rose, L. E., Mallinson, R. K., & Walton-Moss, B. (2004). Barriers to family care in psychiatric settings. Journal of Nursing Scholarship : An Official Publication of Sigma Theta Tau International Honor Society of Nursing / Sigma Theta Tau, 36(1), 39-47. doi:10.1111/j.1547-5069.2004.04009.x

Saxe, L., Cross, T., & Silverman, N. (1988). Children's mental health: The gap between what we know and what we do. American Psychologist, 43(10), 800-807. doi:10.1037/0003-066X.43.10.800

Sayal, K. (2006). Annotation: Pathways to care for children with mental health problems. Journal of Child Psychology and Psychiatry, 47(7), 649-659. doi:10.1111/j.1469-7610.2005.01543.x

Schmitz, C. L., & Hilton, A. (1996). Combining mental health treatment with education for preschool children with severe emotional and behavioral problems. Social Work in Education, 18(4), 237-49.

Stormont, M. (2002). Externalizing behavior problems in young children: Contributing factors and early intervention. Psychology in the Schools, 39(2), 127-138. doi:10.1002/pits.10025

Tomasello, N. M., Manning, A. R., & Dulmus, C. N. (2010). Family-centered early intervention for infants and toddlers with disabilities. Journal of Family Social Work, 13(2), 163-172. doi:10.1080/10522150903503010

APPENDIX A: IRB APPROVAL

DATE: March 11, 2012

TO: Melissa McCanney
FROM: University of St. Thomas Institutional Review Board

PROJECT TITLE: [286591-1] Mental Health Professionals Views on Early Intervention
                       Treatment Barriers
REFERENCE #:
SUBMISSION TYPE: New Project

ACTION: APPROVED
APPROVAL DATE: March 11, 2012
EXPIRATION DATE: March 11, 2013
REVIEW TYPE: Exempt Review

REVIEW CATEGORY: Expedited review category # *[enter category, or delete line]*

Thank you for your submission of New Project materials for this project. The University of St.
Thomas Institutional Review Board has APPROVED your submission. This approval is based on
an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All
research must be conducted in accordance with this approved submission.

This submission has received Exempt Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project
and insurance of participant understanding followed by a signed consent form. Informed consent
must continue throughout the project via a dialogue between the researcher and research
participant. Federal regulations require that each participant receives a copy of the consent
document.

Please note that any revision to previously approved materials must be approved by this
committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and
SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please
use the appropriate reporting forms for this procedure. All FDA and sponsor reporting
requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported
promptly to this office.

This project has been determined to be a project. Based on the risks, this project requires
continuing review by this committee on an annual basis. Please use the appropriate forms for this

procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of March 11, 2013.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Eleni Roulis at 651-962-5341 or e9roulis@stthomas.edu. Please include your project title and reference number in all correspondence with this committee.

Best wishes as you begin your research.

Thank you for such a well written protocol.

Eleni

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of St. Thomas Institutional Review Board's records.

APPENDIX B: E-MAIL SCRIPT AND CONSENT

Barriers Faced by Children and Families When Accessing Mental Health Service

Dear Fraser Employee,

My name is Melissa McCanney. I am currently a Fraser employee and am working towards my Master's degree in Social Work. I am conducting a study as a graduate student at the School of Social Work, St. Catherine University, and University of St. Thomas and I am being supervised by Dr. Colin Hollidge.   The study focuses on the barriers families and children face when attempting to access mental health services. I invite you to participate in this research. You were selected as a possible participant because of your current work with Fraser. Feel free to e-mail me if you have any questions about the study.

If you agree to be in this study, I will ask you to complete an on-line survey that will take approximately 5 minutes. Questions are themed around the barriers families and children face when accessing mental health services. There are no risks or benefits to participating in this study.

The answers to the survey will be submitted anonymously and all information will be kept anonymous.

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with Fraser, St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time prior to submitting the survey without penalty.

You may ask any questions you currently have by e-mail (mcca0300@stthomas.edu) or by phone (651-334-9625). You may also contact my research supervisor, Dr. Hollidge at 651-962-5818 with questions. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

Statement of Consent:
I have read the above information. My questions have been answered to my satisfaction. By submitting the survey, I have given consent to participate in the study.

APPENDIX C: SURVEY QUESTIONS

1. What is your primary position with Fraser?
   a. Case Manager
   b. Mental Health Practitioner (any level)
   c. Social Worker/Psychologist/Other Mental Health Provider
   d. Intake or Assessment
2. How long have you worked in a Child Mental Health program?
   a. 0-1 years
   b. 1-3 years
   c. 3-5 years
   d. 5-7 years
   e. 7 or more years
3. How many children do you currently have on your caseload or meet with per week?
   _____
4. What is the average age of children on your current caseload or meet with per week?
   _____
5. Within your current caseload, the majority of children are of what race?
   a. Caucasian
   b. African American
   c. Hispanic or Latino
   d. Native American/American Indian
   e. Asian/Island Pacific
   f. Other (please specify)
6. Please rate the following access barriers on how they affect mental health treatment?
   - Not a barrier; somewhat of a barrier; a significant barrier; a major barrier
   a. Lack of program knowledge
   b. Transportation
   c. Cost
   d. Insurance coverage
   e. Referral difficulties
   f. Program restrictions or requirements
   g. Lack of support by professionals
   h. Scheduling Difficulties
   i. Culturally insensitive
7. Please rank the top 3 treatment barriers you encounter with clients?
   a. Lack of program knowledge
   b. Transportation
   c. Cost
   d. Insurance coverage
   e. Referral difficulties

    f. Program restrictions or requirements

    g. Lack of support by professionals

    h. Scheduling Difficulties

    i. Culturally insensitive

8. Please rate the following family barriers and the affect they have on treatment.

   - Not a barrier; somewhat of a barrier; a significant barrier; a major barrier

    a. Family Acceptance

    b. Family Engagement/Participation

    c. Poverty

    d. Cultural Barriers

    e. Stigma

    f. Lack of family support

9. Please rank the top 3 family barriers you encounter with clients.

    a. Family Acceptance

    b. Family Engagement/Participation

    c. Poverty

    d. Cultural Barriers

    e. Stigma

    f. Lack of family support