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ScienceDirect
Research in Developmental Disabilities 28 (2007) 119–129
Research in Developmental Disabilities

A mental health clinic for toddlers with developmental delays and behavior problems

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Received 16 January 2006; accepted 9 February 2006

Abstract

A mental health clinic was developed for toddlers with developmental disabilities and significant behavior problems from families living in poverty. The clinic was a collaborative effort between a community-based Birth-to-Three agency and a university. The purpose of this clinic was threefold: to provide direct mental health services for these young children, to train graduate students to work with this population, and to begin to contribute to the limited research available in this area. This paper describes the clinical intake procedures and outcomes for the 81 children served by the clinic over a 2-year period. Referral concerns included tantrums, aggression, oppositional behaviors, hyperactivity, and self-injury. The children came from a diverse group of families living in poverty; single mothers with less than a high school education headed most of the households. The clinical intake included direct observations of parent–child interactions, child behavior assessments, and parental interviews and self-report measures. For the present sample, 77% of the children met the criteria for a developmental disability and nearly 70% also met the criteria for a psychiatric disorder. The most common diagnosis was oppositional defiant disorder. Discussion regarding the challenges inherent in working with families of toddlers with developmental delays and psychiatric disorders living in low-income circumstances is included.

Keywords: Toddlers; Behavior problems; Developmental delay; Mental health clinic

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doi:10.1016/j.ridd.2006.02.001

1. Introduction

Behavior problems in very young children are common and may persist well into the elementary school years and even beyond (Campbell, 1995). Over time, these behavioral difficulties can escalate in severity and result in a number of psychiatric diagnoses including oppositional defiant disorder, conduct disorder, attention deficit hyperactivity disorder, separation anxiety disorder and pervasive developmental disorder, among others (APA, 2000). While there is some consensus that the prevalence of psychiatric disorders in children is generally between 15 and 20% (Wicks-Nelson & Israel, 2006), we currently do not have similar data available for toddlers. When a diagnosis of developmental delay is added, even less is known about the occurrence of challenging behaviors and related mental health problems in these young children. Feldman, Hancock, Rielly, Minnes, and Cairns (2000) reported that children with developmental disabilities as young as 2 years of age showed an increase risk for behavior problems compared to their same aged peers without developmental delays. Comparing a sample of 3-year-old children with or without developmental delays, Baker, Blacher, Crnic, and Edelbrock (2002) found that the children with delays were three to four times as likely to score in the clinical range on a child behavior scale. Moreover, available data suggest that psychiatric disorders occur three to six times more often in children with developmental disabilities than in normally developing children (Matson & Barrett, 1993; Tonge, 1999) and are likely to persist over time (Green, O'Reilly, Itchon, & Sigafoos, 2004). The at-risk status for very young children with developmental disabilities and psychiatric disorders is further exacerbated when these children live in poverty (Aber, Jones, & Cohen, 2000). Normally, developing young children from low-income, mother-headed households are at increased risk for developing behavior problems (Olson, Ceballo, & Park, 2002). When considering that parenting stress already is high among mothers of children with developmental delays (Rodriguez & Murphy, 1997), the additional burden of poverty is likely to increase the vulnerability of these children to develop psychiatric disorders.

Families living in these challenging circumstances are clearly in need of mental health services to help them better understand and manage their young children, and to prevent their behaviors from escalating and becoming more intractable over time when they will be more difficult and expensive to treat. For toddlers with developmental delays, Birth-to-Three programs are available in every state and provide a range of services to maximize the child's developmental progress in their early critical years (*Public Law 108-446–Individuals with Disabilities Improvement Act of 2004*, *Part C – Early Intervention Programs for Infants and Toddlers with Disabilities*). Normally, services include special education, physical, occupational and/or speech therapy, social services, and nursing. However, when considering that the current state of mental health services in this country for children in general is in crisis (Tolan & Dodge, 2005), it should come as no surprise that providing mental health services within Birth-to-Three agencies is not common. In a survey conducted by the U.S. Department of Education (2002), less than 3% of infants and toddlers enrolled in early intervention programs in 2000 received mental health services.

The purpose of this paper is to describe the development of a mental health clinic within a Birth-to-Three agency serving a low-income population of families in a large urban area. This clinic was a collaborative effort between a community-based agency and a university and included the training of graduate students in mental health fields. Its primary mission was to meet the needs of toddlers who were specifically referred for significant behavior problems. Intake data for the children served in this clinic and their families over a 2-year period are presented.