

EARLY INTERVENTION/EARLY CHILDHOOD SPECIAL EDUCATION (EI/ECSE)
AND EARLY CHILDHOOD MENTAL HEALTH SERVICES:
A QUALITATIVE STUDY OF PROGRAMS IN OREGON

by

KAREN A. LAWRENCE

A DISSERTATION

Presented to the Department of Special Education
and Clinical Sciences
and the Graduate School of the University of Oregon
in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy

September 2008

University of Oregon Graduate School

Confirmation of Approval and Acceptance of Dissertation prepared by:

Karen Lawrence

Title:

"Early Intervention/Early Childhood Special Education (EI/ECSE) and Early Childhood Mental Health Services: A Qualitative Study Of Programs In Oregon"

This dissertation has been accepted and approved in partial fulfillment of the requirements for the Doctor of Philosophy degree in the Department of Special Education and Clinical Sciences by:

Jane Squires, Chairperson, Special Education and Clinical Sciences
Deborah Olson, Member, Special Education and Clinical Sciences
Debra Eisert, Member, Special Education and Clinical Sciences
Ellen Scott, Outside Member, Sociology

and Richard Linton, Vice President for Research and Graduate Studies/Dean of the Graduate School for the University of Oregon.

September 6, 2008

Original approval signatures are on file with the Graduate School and the University of Oregon Libraries.

© 2008 Karen A. Lawrence

An Abstract of the Dissertation of
Karen A. Lawrence for the degree of Doctor of Philosophy
in the Department of Special Education and Clinical Sciences

to be taken September 2008

Title: EARLY INTERVENTION/EARLY CHILDHOOD SPECIAL EDUCATION
(EI/ECSE) AND EARLY CHILDHOOD MENTAL HEALTH SERVICES:
A QUALITATIVE STUDY OF PROGRAMS IN OREGON

Approved: _____
Dr. Jane Squires

Incorporation of a mental health focus into Early Intervention/Early Childhood Special Education (EI/ECSE) services is considered critical by many professionals due to the vulnerability of young children with disabilities to developing behavior problems, mental health disorders, and to experiencing maltreatment. This qualitative research study investigated ways personnel in EI/ECSE agencies in Oregon are addressing the mental health needs of the children and families they serve. How mental health is conceptualized by EI/ECSE providers, how well prepared providers are in addressing the needs, what kinds of strategies are used to serve children and families, and how adequately EI/ECSE families and children are served by the mental health system were

explored. The study was divided into two parts, which included a state-wide study of 14 EI/ECSE agencies in five regions in Oregon, and an in-depth study of one EI/ECSE agency that has employed a mental health consultant. State-wide agencies were mainly located in rural parts of the state, although two education service districts in metropolitan areas were included. The perspectives of 10 mental health providers from community mental health centers were also collected. The most salient issues that surfaced in the state-wide study included the focus of EI/ECSE concern on behavioral and mental health problems in children ages three through five and strategies for related behavior management in classroom settings, the importance of collaboration with community agencies, and a desire for increased partnership with mental health. Interviews with both EI/ECSE and mental health agencies revealed problems in the mental health system including training of therapists in working with very young children, gaps in services for children who were not Medicaid-eligible and in services for parents with their own psychological issues, and in the capacity to serve all of the children who were referred. The in-depth study focused on one EI/ECSE agency that was developing staff competence in relationship-based work with families through support from a mental health consultant employed by the agency. Salient issues included funding for a mental health consultant in an educational agency, development of mental health services for early childhood through community collaboration, and supporting staff through reflective supervision.

CURRICULUM VITAE

NAME OF AUTHOR: Karen A. Lawrence

PLACE OF BIRTH: Los Angeles, California

DATE OF BIRTH: August 1, 1952

GRADUATE AND UNDERGRADUATE SCHOOLS ATTENDED:

University of Oregon, Eugene
University of California, Santa Cruz

DEGREES AWARDED:

Doctor of Philosophy, Early Intervention, 2008, University of Oregon
Master of Science, Early Intervention, 2002, University of Oregon
Bachelor of Arts, Art History, 1975, University of California, Santa Cruz

AREAS OF SPECIAL INTEREST:

Early Childhood Mental Health
Parent Advocacy
Systems Change

PROFESSIONAL EXPERIENCE:

Graduate Teaching Fellow, Educational Studies, University of Oregon, Eugene,
2006

Research Assistant, Early Intervention Program, University of Oregon, Eugene,
2002

Program Secretary, Early Intervention Program, University of Oregon, Eugene,
1984-1988, 1992-2002

Secretary, Mt. Hood Community Mental Health Center, Gresham, Oregon, 1988-1992

GRANTS, AWARDS AND HONORS:

Doctoral Personnel Preparation Grant, U.S. Department of Education, 2003-2005, 2007

Doctoral Personnel Preparation Grant, U.S. Department of Education, 2008

ACKNOWLEDGMENTS

I would like express my deep appreciation to Dr. Diane Bricker, who invited me to become a doctoral student and who has so kindly guided me through my transformation from secretary to Ph.D. Thank you to Dr. Jane Squires for her generosity and flexibility and opportunities to participate in the research world. I appreciate having been part of the Early Intervention Program for so long and to have opportunities to participate in writing, teaching, research, and friendship with faculty and my fellow students and co-workers. The financial support I have received through the Early Intervention Program from doctoral personnel preparation grants awarded by the Office of Special Education Programs, U.S. Department of Education has allowed me to deepen and broaden my education, and I look forward to contributing back to my field in return.

Thank you to my dear family for your unconditional support and for being so patient, proud and enthusiastic during my long course of study.

DEDICATION

For the EI/ECSE providers and families

TABLE OF CONTENTS

Chapter	Page
I. INTRODUCTION	1
Mental Health Disorders in Children with Disabilities	3
Behavior Problems in Children with Disabilities	6
Maltreatment of Children with Disabilities	14
Families Who Have a Child with a Disability	19
Understanding the Family System and Reactions to Stress.....	20
Families from Diverse Cultures	23
Depression	25
Summary	30
Purpose of the Study and Research Questions.....	31
II. REVIEW OF LITERATURE	32
EI/ECSE Services in Oregon	34
Eligibility for EI/ECSE Services	35
Mental Health Services for Children	40
Prevention and Early Intervention for Mental Health Problems	44
Behavioral Support	45
Mental Health Consultation in Early Childhood Programs	47
Infant Mental Health	50
Summary	52
Mental Health Supports in the EI/ECSE System.....	53
Working Through the Relationship	56
Working with the Relationship	58
Incorporation of Mental Health Models in EI/ECSE Systems	60
Rhode Island	61
Maryland	63
Illinois	64
Conclusion	67

Chapter	Page
III. METHOD OF STUDY	68
Introduction.....	68
Part 1: Interviews from Across the State of Oregon.....	69
Participants.....	70
Measures	77
Part 2: In-depth Case Study	83
Participants.....	83
Measures	87
Interview Transcription and Data Analysis	88
Sharing Results with Participants	90
Trustworthiness.....	91
Clarifying Researcher Biases.....	91
Triangulation.....	92
Member Checks and Returning to the Original Transcripts	93
Protection of Human Subjects	94
Personal Influences and Ethical Considerations.....	95
IV. STATE-WIDE STUDY: EI/ECSE PARTICIPANTS' DEFINITIONS OF AND STRATEGIES FOR WORKING WITH MENTAL HEALTH PROBLEMS	97
Organization of Results	97
Introduction.....	98
Describing the Mental Health Needs in Children and Families	99
The Issue of Mental Health in EI/ECSE.....	100
Definitions of Mental Health Problems.....	107
The Ability of EI/ECSE Agencies to Support Children's Social-Emotional Development and the Mental Health Needs of Families	114
Expertise in Behavior Management Among EI/ECSE Staff	115
Programs with Behavior Specialists	121
Programs with Mental Health Consultation.....	126
Summary of Issues.....	133
A Richer Contextual View of How EI/ECSE Agencies Function.....	136
Vignette 1: Interagency Collaboration to Overcome Scarcity of Resources in an Isolated Frontier County	136
Vignette 2: Education of a Whole Community in the Social-Emotional Needs of Children.....	142

Chapter	Page
Vignette 3: Supporting Parents with Mental Health Problems.....	144
Vignette 4: A Prevention Model in the Community.....	150
 V. STATE-WIDE STUDY: MENTAL HEALTH SERVICES FOR CHILDREN AND FAMILIES IN THE EI/ECSE SYSTEM.....	 153
Introduction.....	153
Summary of Recommendations from EI/ECSE Providers	153
The Importance of Working Relationships.....	155
Collaborative Working Relationships.....	157
“Poor” Working Relationships	160
The Capacity of Mental Health Agencies to Serve EI/ECSE	165
Serving the Early Childhood Population	167
Hiring and Retaining Qualified Providers	172
Gaps in Services for Children.....	175
Limited Services for Families.....	179
Discussion of Issues.....	182
 VI. IN-DEPTH CASE STUDY OF AN AGENCY WITH MENTAL HEALTH CONSULTATION.....	 186
Introduction.....	186
How Mental Health Consultation Came to the Agency	187
Issues Around Funding a Mental Health Consultant.....	191
Collaborative Work in the Community to Build Children’s Mental Health Services	194
The Work of Mental Health Consultation	195
The Boundaries of Mental Health Work in EI/ECSE.....	201
Eligibility for Children with Mental Health Needs	204
Partnering with Community Mental Health.....	210
Future Directions	214
Summary	215
 VII. IMPLICATIONS OF THE STUDY	 220
EI/ECSE’s Role as a Partner for Mental Health Services	220
The Focus of Concern on Preschool-Age Children	222
The Barriers to Funding Mental Health Consultation in EI/ECSE.....	224
Contributions to the Literature.....	225
Limitations of the Study	225

Chapter	Page
Future Directions	228
BIBLIOGRAPHY	230

LIST OF FIGURES

Figure	Page
1. How EI/ECSE Providers Described the Issue of Mental Health in Children and Families.....	106
2. The Ways EI/ECSE Providers Defined Mental Health Problems	110
3. Strategies Used by EI/ECSE Programs for Working with Children and Families With Mental Health Concerns.....	135
4. Summary of Recommendations from EI/ECSE Providers	155
5. Kinds of Working Relationships Identified Between EI/ECSE and Mental Health Agencies.....	165
6. Summary of the Important Issues in the In-Depth Study	216

LIST OF TABLES

Table	Page
1. Types and Numbers of Providers Interviewed for the State-Wide Study.....	74
2. Rural/Urban Characteristics of Counties and Indian Reservation (N = 18).....	76
3. Number of Children Served by EI/ECSE Agencies in the State-Wide Study	76
4. Interview for EI/ECSE State-Wide Personnel	78
5. Interview for Mental Health Personnel Who Serve EI/ECSE Families	80
6. Questions Used with Mental Health Providers Beginning May 2008.....	84
7. Participant Roles in the In-Depth Study	86
8. Types and Numbers of Providers Interviewed for the In-Depth Study.....	87
9. Initial Interview Questions for the In-Depth Case Study	88
10. Four Vignettes: Overview of Agency Solutions to Problems in Context.....	137
11. Problems in the Capacity of Mental Health Agencies that Become Barriers to Services for EI/ECSE Children and Families	166

CHAPTER I

INTRODUCTION

Since the mid-1980s, special education laws have encouraged states to establish public systems for young children with disabilities from birth to school age (Bowe, 2004). The Individuals with Disabilities Education Act (IDEA), Part C specified the incorporation of family-centered services that support children's development in cognitive, physical, and social development. Yet most state systems have been designed without a focus on children's social-emotional development, particularly for children who have serious emotional or behavioral disorders, or on their early mental health development (Knitzer, 2000). Early childhood mental health is a field of growing concern that has received increasing public attention affecting all the service systems that are used by young children and their families (Shonkoff & Phillips, 2000).

Knitzer (2000) argues that systems development in early childhood mental health is a critical need. Meeting the mental health needs of young children with disabilities and their families can only occur through collaboration between early childhood special education, childcare, mental health, child welfare, and other systems that serve this population (Guralnick, 2005; Kaufmann & Hepburn, 2007).

This study will explore the contributions that can be made by the field of early intervention/early childhood special education (EI/ECSE) to the social-emotional development of young children with disabilities and the mental health needs of these

children and families. The first chapter offers a perspective on the characteristics of children and families who receive services in EI/ECSE that make them particularly vulnerable and in need of mental health support. The second chapter explores the current services in EI/ECSE and early childhood mental health. Ways that mental health practices have been brought into EI/ECSE will be examined with the intent of providing a base of understanding how these activities are occurring nationally. The focus of the proposed study will be an exploration of how EI/ECSE agencies in Oregon define the issue of mental health among the families and children they serve, how they address mental health needs through internal capacity and interfacing with the mental health system, and where personnel in the EI/ECSE and mental health systems see avenues for increased collaboration and capacity building.

The young children served in special education programs fall within a much larger group of children from all social classes and backgrounds that are vulnerable to mental health disorders. Certain factors increase the risk of all children, including family history of substance abuse and mental illness, abuse and neglect, multigenerational poverty, low birthweight, separation from their caregiver, physical problems, and low intellectual functioning (U.S. Surgeon General, 1999). However, the rate of mental health disorders and child maltreatment is higher in children with disabilities than in the population of typically-developing children (Batshaw & Perret, 1992; Steinberg & Hylton, 1998). Families who have a child with a disability often face uniquely stressful challenges that have the potential to impair their family functioning, which in turn affects how well they support the mental health of their children (Turnbull et al., 1993). This is

particularly true among families in more difficult life situations in which they are experiencing financial stress, family disruptions, and parental psychological disturbances (Harbin, 2000). These issues will be discussed below.

Mental Health Disorders in Children with Disabilities

The high prevalence of mental health disorders among children with disabilities was first systematically studied by Rutter, Graham, and Yule in their 1970 epidemiological research among the entire population of public school-age children on the Isle of Wight. A portion of their study was designed to answer the question of whether the rate of psychiatric disorder is higher in children with organic brain dysfunction, and if so, to identify its causes (i.e., whether it was due to biological brain disorder or to environmental causes). In their study, organic brain dysfunction included cerebral palsy, mental retardation, epilepsy, and other brain disorders. A prevalence rate of psychiatric disorder of 34% was found among children who attended school, and 50% among children who were excluded from school due to the severity of their disability. A comparable rate of 6.6% occurred among their peers without disabilities (Rutter et al., 1970).

The Rutter study was conducted before special education laws were enacted for all children with disabilities in England and the United States; however, its high prevalence rate has been confirmed in subsequent studies (Feinstein & Reiss, 1996). Currently, the risk for children with mental retardation to develop psychiatric and behavioral disorders is believed to be 4-5 times that for children who do not have this

disability (Batshaw, 2002; Merrell, 2003). Children with other disabilities such as seizure disorders, traumatic brain injury, neurodevelopmental (e.g., fetal alcohol related disorders), and language disorders also have higher rates of psychiatric disturbances than children without disabilities (Batshaw & Perret, 1992). Children with more severe disabilities have generally higher rates of mental health problems (Batshaw & Perret, 1992). Many children with moderate and severe disabilities are diagnosed early in life (Bowe, 2004) and these children are served in the U.S. in public EI/ECSE programs.

For much of the past century, authorities debated whether children with mental retardation in particular could experience mental illness. Behaviors resulting from the frequent co-existence of psychiatric problems and mental retardation were believed for many years to be characteristics of mental retardation itself, especially in cases of severe mental retardation (Batshaw & Perret, 1992). It is now understood that children with and without disabilities are at risk for the same kinds of psychiatric disorders (Batshaw, 2002; Feinstein & Reiss, 1996), but that children with disabilities are susceptible at a much higher rate.

Research on developmental disabilities has continued to focus on identifying the causes of behavioral and psychiatric disorders in this population. Behavioral research distinguishes between the direct effects of various genetic syndromes on a child's patterns of behavior and the indirect effects children's behaviors have on their caregivers and other people (Hodapp, 1997). Research has focused in recent years on defining behaviors associated with the direct effects of different syndromes; however, only a few syndromes that have unique psychiatric disorders have been identified (e.g., extreme

overeating associated with Prader-Willi syndrome; compulsive self-injury associated with Lesch-Nyhan syndrome) (Hodapp & Burack, 2006). Instead, theories of the genesis of psychiatric disorders in children with developmental disabilities focus on the interplay of the individual child's biological strengths and weaknesses (i.e., direct or innate effects) and their interactions and transactions with their caregivers and others in their environment (i.e., indirect or environmental effects) (Batshaw, 2002; Hodapp & Burack, 2006). Neurobiological weaknesses may place children with mental retardation at higher risk for behaviors such as irritability, impulsivity, distractability, and developing poor communication skills, and short attention span (Feinstein & Reiss, 1996). The risks for these behaviors are higher in children whose mental retardation is associated with in-utero alcohol and drug exposure, neural tube defects, prematurity, brain hemorrhage, and cerebral palsy (Feinstein & Reiss, 1996).

Feinstein and Reiss (1996) describe the extent of the psychosocial problems experienced by many children with mild mental retardation (i.e., IQ between 50-55 and 70). About 20% of preschool-age children served in EI/ECSE programs who are eligible because they have a developmental delay, but are not yet identified with a specific disability, will probably be diagnosed with mild mental retardation by early elementary school (Delgado, Vagi & Scott, 2006).

Feinstein and Reiss (1996) have speculated on the interplay between child and environmental characteristics that may lead to behavioral and psychiatric problems. Mild mental retardation has been associated in many epidemiological studies with high risk families who have many risk factors, such as financial stress, low maternal education, a

parent with psychiatric illness, and social isolation (e.g., Sameroff, Seifer, Baldwin, & Baldwin, 1993). Lack of stimulation at home may compound delays in communication skills. Characteristics of difficult temperament and poor attention skills may make children with mild mental retardation a target of neglect or physical abuse from their families in early childhood (Garbarino, 1989). Cognitive processing abilities may contribute to the failure to fully participate in peer-group activities. Early rejection and teasing of the child and repeated failure to interact with peers decrease the child's opportunities to learn social skills and increase poor self-esteem (Feinstein & Reiss, 1996).

Serious mental health problems in children with mental retardation usually emerge in adolescence (Feinstein & Reiss, 1996), but their precursors are apparent in early childhood. Research in the field of EI/ECSE has focused on the unusual number of children with mild developmental (cognitive) delays and other disabilities who experience difficulty socializing cooperatively with peers (Odom, McConnell & McEvoy, 1992). The difficulties in establishing relationships or forming friendships with peers appear to be stable over time because they are reinforced by peer rejection and subsequent limitation of social partners (Guralnick, Neville, Connor & Hammond, 2003).

Behavior Problems in Children with Disabilities

It is believed that many psychiatric disorders in childhood manifest first as behavior problems (Severson & Walker, 2002). Early signs of these problems include poor social skills, physical cruelty, aggression, and concerns of caregivers that the child

is unmanageable (Kazdin, 2000). Disruptive behavior problems such as conduct disorder have received the widest research attention, and have been linked to psychiatric illness later in life (Kazdin, 2000).

It should be noted that a small proportion of children manifest neuropsychiatric, neurobiological, or neurodevelopmental problems that are caused by biological abnormalities. These are distinguished from emotional and behavioral disorders that develop through influence from the social environment (Taylor, 2003). The terms *mental illness* for adults and *severe emotional disorders* for children (i.e., early onset before age 15) are commonly used for this type of mental disorder (Taylor, 2003), which include “schizophrenia; mood disorders; pervasive developmental disorders; attention-deficit hyperactivity disorder; panic attacks; and obsessive-compulsive disorder” (p. 40). Many of these types of disorders (i.e., panic attacks, mood disorders) develop in children who do not have organic abnormalities. However, children with neuropsychiatric disorders are distinguished from those with other serious mental disorders through ruling out children’s short-term reactions to environmental crises (e.g., family disruption) or from life-threatening experiences (e.g., witnessing extreme violence) or long-term symptoms from maltreatment or other environmental stressors. Genetic predisposition (i.e., having family members with a diagnosed psychiatric disorder) is the most common risk factor (Taylor, 2003). The rest of this section will be devoted to research on behavior problems that are the related to social-environmental influences.

In early childhood, the difficulty arises of distinguishing between behaviors that are on a trajectory toward psychiatric disorders, and behaviors that are transitory and part

of normal adjustment in childhood (Kazdin, 2000). The majority of children's challenging behavior problems do not persist past the preschool age (Campbell, 2002). Behavior problems are very commonly reported by parents and teachers, and the focus of adult worries follows children's stages of maturation (Campbell, 2002). In infancy, the most frequent concerns focus on eating, sleeping and crying. Feeding and sleeping difficulties continue to be reported up to age 2, when toileting becomes the focus. The majority of parental concerns are reported around age 3, when difficulties with discipline and peer-interactions predominate. Problems with peers, self-regulation, tantrums and over-activity appear to decrease after age 3 in most children (Campbell, 2002).

Problem behaviors must be placed in the context of children's development. Even though most children "grow out of" childhood problems, serious psychological disorders do occur in very young children. They manifest through the behaviors that preoccupy the child at specific stages of development, such as eating, sleeping, and toileting (Reams, 2006). In order to distinguish serious and persistent behavior disorders from "normal" or expected early childhood problems, researchers have looked for clusters or patterns of behavior that occur together and have the potential of disrupting children's development. Campbell (2002) described the two major types, externalizing and internalizing disorders. Externalizing behaviors can be described as occurring because of lack of self-control and are exhibited when the child acts out on the environment against other people and property. Externalizing behaviors include tantrums, fighting, destructive behavior, overactivity, and defiance. Internalizing behaviors, on the other hand, are associated with too much self-control. They can be seen in social withdrawal, anxiety, and fearfulness.

The presence of behavior disorders or potential disorders is identified by a pattern of behaviors rather than single, discrete behaviors. Assessment of behavior disorders takes into consideration how much they are interfering with the child's necessary tasks of development. The behavior's intensity, how often behaviors occur, over what period of time, in what social context, and how they are viewed by adults are all taken into consideration (Campbell, 2002).

It is important to identify serious behavior problems early, before they turn into disorders. Once serious problems develop, it appears that they persist in many young children (Severson & Walker, 2002). Most of the studies on the stability of behavior problems have been done on clinical or high risk populations (Campbell, 2002). However, Lavigne and his colleagues (1998) identified a pattern of behavior problems in preschool-age children from community pediatric practices. They followed a group of 2- to 5-year-old children over three data collection periods approximately a year apart (i.e., the children were 2 to 5 years old when the study began and 4 to 9 years old by the end of the study). The majority of children who received a mental health diagnosis were identified with a disruptive behavior pattern at the initial evaluation (i.e., oppositional defiant disorder, conduct disorder, or attention deficit disorder). A smaller proportion of children received a diagnosis of emotional disorder (i.e., phobia, anxiety disorders, depressive disorders and post traumatic stress disorder). Of the children who were diagnosed in the first assessment, approximately 50% of the 2- to 3-year-olds and 65% of the 4- to 5-year-olds still had a disorder a year later. By the third year, 76% of the same children continued to have a disorder. Even among children who did not receive an initial

diagnosis, approximately 17-20% had received a diagnosis by the second or third data collection period. Evidence of the stability of serious behavior problems in early childhood supports the need for early clinical interventions (Lavigne et al., 1998).

A great deal of research has been done recently on the alarming incidence of behavior problems in the general early childhood population, particularly in children from low-income backgrounds (Conroy & Brown, 2004). Prevalence rates of behavior problems among preschool children reported in the literature vary greatly depending on the population being examined (Qi & Kaiser, 2003). In a review of studies since 1991 that employed behavior checklists with adequate psychometric qualities, Qi and Kaiser identified prevalence rates among children in a broad range of SES situations between 7% and 13%. The prevalence of behavior problems in studies of children from low-income families in Head Start were higher, between 16% and 30% for externalizing problems and 7% to 31% for internalizing problems. In studies of children from a wider range of settings, the prevalence of behavior problems appeared to vary depending on family characteristics. For example, in samples of children who had low-income teen mothers, two studies reported externalizing behaviors in the clinical range of 33-36% among preschool children.

A study on the behavior problems specific to the early childhood special education population in the 1980s by Blackman and Cobb (1989) concluded that common behavior problems of early childhood (e.g., colic, feeding difficulties, and temper tantrums) are reported at a higher rate in the first year of life by parents of children who are developmentally at risk than parents of typically-developing children.

The children in this study had not yet been diagnosed with developmental problems, and this reflects a common phenomenon among many parents who suspect that something is wrong in their child's development long before diagnosis. In this study, concerning behaviors in the first year of life clustered around body tone (e.g., stiffness, limpness), under-activity, and feeding problems. Parents reported that concerning behaviors lasted longer than parents of normally developing children, and were more worrisome to them (Blackman & Cobb, 1989). Eating disorders (i.e., rejection of a range of foods, fighting over feeding) and sleep disorders have been found to be common in children with mental retardation and autism (Nickel, 2000). Feeding problems are influenced by the characteristics of the child's disability, health, and the child's temperament, as well as the parent's feeding skills and family eating patterns. They can sometimes be an indication of difficulties in the relationship between the parent and child (Jepson & Nickel, 2000).

There is very little information published on how programs that serve children with disabilities identify those who have challenging behaviors (Powell, Fixsen, Dunlap, Smith & Fox, 2007). The most current information on the numbers and kinds of behaviors facing EI/ECSE programs comes again from parent report, in the findings of the National Early Intervention Longitudinal Study (NEILS). This national study looked only at services for the birth to three age range. The initial NEILS data identified an incidence pattern of behavior across many different behavior items identified by parents (Twenty-third Annual Report to Congress, 2001). About one-third of parents reported their child had some behavior problems, and 10-40% reported their children had challenging behaviors of various types. Behaviors included excitability and high activity

(i.e., 30% reported this quality characterized their child and 30% reported it sometimes) and aggression with other children (i.e., 50% reported sometimes and 11% reported often). Nineteen percent of parents reported frequent problems with sleep. Parents' difficulty in figuring out what to do with their children's behavior increased with the child's age. These numbers held steady for children after they had been in early intervention for one year, particularly for children who entered services as toddlers (Twenty-fourth Annual Report to Congress, 2002).

Often, behavior problems in young children with disabilities have to become quite severe and cause upset in the family or childcare before they are recognized. Drotar and Sturm (1991) suggested that the following three issues should be looked at when considering if a young child needs to be referred for assistance with behavior problems: a) whether the child's behavior is interfering with developmental progress associated with his/her age and disability level; b) whether the child's behavior is hindering progress in educational or developmental services; and c) whether the parents and other caregivers are highly stressed or anxious about the interpersonal or psychological functioning of the child. They advised that any one of these issues gives cause for further evaluation. It is unfortunately the case that most children with serious behavior problems are not identified prior to entering elementary school, and many more years elapse before they are referred for special education services or mental health treatment (Severson & Walker, 2002).

The most common reason for referring a young child to mental health services is for aggressive and noncompliant behaviors that may indicate a child has or is developing

conduct disorders or antisocial behavior patterns (Severson & Walker, 2002). Conduct disorder is diagnosed by identifying a persisting pattern of violating age-appropriate social norms and the rights of others. It is associated with significant impairment in functioning (Kazdin, 2000). Many children with conduct disorder have co-morbid diagnoses of oppositional defiant disorder (approximately 80%) or attention deficit hyperactivity disorder (45-70%), and sometimes with depression and anxiety disorders (Kazdin, 2000).

Conduct problems in children are one of the most widely researched problems of childhood, because once they become severe enough to be diagnosed as conduct disorder, few treatments are effective (Severson & Walker, 2002). Youth with conduct disorder present a great cost to society in terms of their use of the mental health and criminal justice systems. Most youth with conduct disorders will suffer psychiatric illness in adulthood (Kazdin, 2000).

Work on identifying the causes of conduct disorder has focused on child, parent and family characteristics that increase the likelihood of its development in childhood. Risk factors operate in a complex fashion, and several risk factors usually affect child and family functioning concurrently and interactively (e.g., poor child supervision, domestic violence, and criminal activity of parents) (Kazdin, 2000). Research has repeatedly confirmed that risk factors act cumulatively, such that one or two factors may not be associated with an increase in risk, but when a tipping point is reached (e.g., four to five risk factors), risk increases sharply (Sameroff, Seifer, Baldwin, & Baldwin, 1993). Kazdin (2000) has described child, parent, and family factors associated with developing

conduct disorders. Child factors include pregnancy and birth complications, a difficult temperament (e.g., frequent negative mood, less adaptability to change) and deficits in language development, abstract reasoning, and attention control, and lower levels of intellectual functioning. The two strongest parent and family factors are alcoholism and criminality. Also associated are interpersonal conflict and aggression between parents, the use of child discipline that is harsh and inconsistent, less attachment and acceptance shown to children, and lack of supervision. Ecological factors include those associated with poverty, such as poor quality housing and unemployment that place more stress on parents and cause them to engage inadvertently in behaviors that aggravate antisocial interactions (Patterson, 1982). At the extremes of family dysfunction, maltreatment of children occurs (Garbarino, 1989).

Maltreatment of Children with Disabilities

Behavior disorders and disability co-occur in a significant proportion of children who suffer maltreatment (Sullivan & Knutson, 2000). Until recently, there has been little attention paid to the neglect and abuse of children who have disabilities and special health care needs (Steinberg & Hylton, 1998). The evidence for abuse of children with disabilities comes from several sources. First, the history of abuse of children and adults with disabilities in residential institutions has been well documented by stories from personnel working in the institutions and by former inmates (Sobsey, 1994). In the years previous to the civil rights movement for people with disabilities and the establishment of free and appropriate education, many children were placed in institutions where sexual

and physical abuse and neglect were common (e.g., Bogdan & Taylor, 1982). Second, hundreds of adults with developmental disabilities are currently abused or neglected each year in Oregon (Oregon Developmental Disabilities, 2007). Third, in recent years, the large proportion of children with disabilities in child protective services has begun to be recognized.

The first federal study of children with disabilities in the child protective services system was produced by the National Center on Child Abuse and Neglect (NCCAN) in 1993 (Ratnofsky & Crosse, 1991; Westat Corporation, 1993). This study reported cases of maltreatment from a nationally representative group of 35 child protection agencies in 1991, and identified at least one disability in 14% of children with substantiated maltreatment. This study estimated that children with disabilities were 2.1 times more likely to suffer physical abuse, 1.8 times more likely to suffer sexual abuse, and 1.6 times more likely to be physically neglected than typically-developing children in the child protective services system.

There is currently no national child welfare reporting system that collects information on the number of children with disabilities who have substantiated cases of child abuse or neglect. In the most recent Children's Bureau report (Administration for Children and Families, 2007), 39 states reported information on children with disabilities. In this report, approximately 8% of children were believed to have a disability, although this was considered a low figure by the Bureau.

Oregon statistics show similar trends. In 2006, 8% of children in foster care in Oregon were removed from the home because of their disabilities; 43% were removed

because of their behavior (half of children entering foster care have four or more reasons for removal) (Oregon Department of Human Services [Oregon DHS], 2007). The identification of prevalence statistics is hindered by the national special education system which allows states to individually define disabilities in the children they serve, and by lack of training among child protection workers (Hibbard & Desch et al., 2007) (e.g., the 1991 NCCAN statistics of maltreated children in the child protective services system were identified based on opinion).

In 2000, Sullivan and Knutson published an epidemiological study designed to improve on some of the faulty research methods used in previous studies to identify the relationship between maltreatment and disability in children. They retrospectively analyzed the entire population of children in the Omaha, Nebraska public school system for the 1994-95 school year, including children who participated in preschool special education programs. Using school-based disability categories to identify children with disabilities, they identified an overall special education rate of 8% in public education. Maltreated children were identified by electronically merging school records with the state's social services central registry, the foster care review board, and police victimization records. They found a rate of maltreatment in the non-disabled school population of 9%; however, the overall rate of children receiving special education on whom there was evidence for maltreatment was 31%. Neglect was the largest category of maltreatment for both non-disabled and disabled children, and children with disabilities were significantly more likely to experience multiple kinds of maltreatment in multiple episodes. Mental retardation made children particularly vulnerable; children with this

disability were almost 4 times more likely to be maltreated than nondisabled children (Hodapp & Burack, 2006). Of particular importance, children with disabilities were found to be maltreated at younger ages than their typically-developing peers. Preschool children with disabilities had significantly more incidents of all types of abuse than children in older age groups.

From these studies, it is clear is that children with disabilities are at an increased risk for being the victims of maltreatment. Sullivan and Knutson's (2000) study focuses on the difficulty of identifying whether, however, disability precedes or is caused by maltreatment in these kinds of prevalence studies. Sameroff and Chandler in 1975 cited findings from studies of children who were battered and were found to be mentally retarded or have physical abnormalities. They made a case that battered children "contribute" to their parents' battering because they are often difficult to manage, have an annoying or difficult temperament, or need more attention because they are ill or hyperactive. Sullivan and Knutson found that behavior disorders and mental retardation occurred in significant association with maltreatment across age ranges and may be both risk factors and consequences of abuse and neglect. They speculated that some types of disabilities associated with younger maltreated children may have preceded maltreatment, particularly communication and health/orthopedic disabilities among the birth to five population.

Abuse and neglect are a significant cause of disabilities in children. In child protective services cases, it is often difficult to document whether a disability preceded or was due to maltreatment (Diamond & Jaudes, 1983, cited in Steinberg & Hylton, 1998;

Sullivan & Knutson, 2000). In the NCCAN 1991 study child protection caseworkers reported that about 15% of children's disabilities were caused or were likely to have been caused by maltreatment. Other evidence comes from research in medical settings. Diamond and Jaudes reported in the early 1980s that 9% of children in a cerebral palsy clinic had acquired the disability from past abuse. In a study of infants under 12 months with head injuries, Billmire and Myers (1985) identified 36% of the injuries as caused by abuse; 95% of the injuries serious enough to cause disability or death were the result of abuse. Finally, Sobsey (1994) attributes a significant proportion of disabilities to injuries in utero due to battering of their mothers while pregnant.

Since 2003, the federal Child Abuse Prevention and Treatment Act has required referral of substantiated cases of children under age three to agencies providing early intervention services where they can receive developmental screening to determine if they are eligible to receive special education services (Keeping Children & Families Safe Act, 2003). Efforts are being made to educate child welfare, education, medical and other personnel to identify children who may have disabilities (e.g., Steinberg & Hylton, 1998). The American Academy of Pediatrics (2007) and the American Psychological Association (2003) have both issued guidance or policy statements about this public health issue to educate professionals in their disciplines.

In general, the abuse of children with disabilities is believed to occur at a higher rate than in the general child population because of several risk factors, but there is a lack of well-designed research (Garbarino, 1989; Sobsey, 1994). The majority of all child abuse and neglect occurs in children's natural families, and this holds true for children

with disabilities (Sullivan & Knutson, 2000). An important factor in child maltreatment is family isolation. In families with a child with disabilities, isolation can be common (Garbarino, 1989; Sobsey, 1994). Singer and Irvin (1991) attempted to identify the factors that contribute to family isolation. Included among them are the demands of intensive caregiving, the difficulty in finding adequate child care, inability to find respite from caregiving, or obtain leisure time. Isolation can be the family's defense against the social stigma of having a member with disabilities, but it contributes to the inability to interact with other families to develop natural social networks. Family isolation is associated with increased mental health problems in parents, including alcohol and drug dependence (Sobsey, 1994). Children who have been damaged by exposure to substances while their mother was pregnant, and have developed fetal alcohol-related disorders or other neurobiological disorders can be especially vulnerable to the family violence that accompanies substance abuse (Sobsey, 1994).

In Oregon, the major stresses that occur in families with founded cases of child maltreatment are substance abuse (in 42% of cases), domestic violence (22%), and parental involvement with law enforcement (25%). Usually these families have several risk factors, and these can also include pregnancy or a new baby in the family (in 12% of cases) and parental history of abuse as a child (11%) (Oregon DHS, 2007).

Families Who Have a Child with a Disability

The relationship of family functioning to the mental health of children with disabilities has been traced through discussions about mental disorders, behavior

problems, and maltreatment. At this point, research on the adaptation of families to having a member with a disabilities will be examined.

Understanding the Family System and Reactions to Stress

Research on the impact of children with disabilities on their families has amassed since the 1950s. Many of the early clinical studies focused on the negative consequences of having a child with a disability, primarily its effect on the mother (Minnes, 1988; Turnbull et al., 1993).

Of particular interest to the EI/ECSE field has been the potential for strong feelings of grief and loss that may be experienced by parents. The model of maternal mourning proposed by Solnit and Stark (1961) has been influential for many years (Hodapp & Burack, 2006). They described a stage model similar to the sequences of stages in the acceptance of death, comparing mourning the birth of a child with disabilities to mourning the loss of their expected perfect child (e.g., Brazelton & Cramer, 1990). Sequential stages of mourning were identified that followed an order of disassociation, emotional disorganization, and finally emotional reorganization. Olshansky (1962, 1966) argued that parents often never stop grieving as the child grows up, and over time re-experience the stages of chronic sorrow, with ups and downs of recurrent emotions as the child experiences medical emergencies or falls behind other children in development. The family's grief reactions are today considered a significant influence on their ability to cope and take in information from EI/ECSE services. An

important part of services is to recognize parents' emotional reactions and be aware of the availability of clinical resources if they are needed (Foley & Hochman, 2006).

Models of stress and coping have also been influential in the study of families' adaptation to a child with disabilities. In 1983, Crnic, Friedrich, and Greenberg proposed a family systems model which incorporated theories from research on stress, coping, and family ecology. Crnic and his colleagues identified the presence of the child with disabilities as a "significant ongoing stressor within the family, precipitating numerous minor and major crises" (p. 133). The family response to the stressor was viewed on a continuum of strengths and weaknesses according to the family's coping resources and ecological supports. McCubbin and Patterson (1983) also published at about the same time an influential model of stress on the family system, called Double ABCX. They used the family's own perceptions and assessments of their stress and coping capacities as the basis of the model (Patterson, 1993). The "Double" in their model refers to the temporal aspects of managing ongoing strains to the family system. The "X" refers to the crises experienced by the family as their child is diagnosed and develops. The "aA" of the model is the stressing event that sets off the family's coping mechanisms. The "bB" refers to the family's perception of their internal and external resources for meeting the crisis. The "cC" refers to how the family makes sense of the stressor (Patterson, 1993). Minnes (1988) expanded the Double ABCX model by integrating previous research. For each of the model's factors, Minnes reviewed the literature on the stress factors experienced by families with a disabled child to identify potential variations in family functioning, and thus to identify points of intervention or areas of needed support.

Minnes' analysis has helped the field to understand families' coping strategies in terms of their unique strengths and needs (Hodapp & Burack, 2006). She identified qualities that may contribute to the original stressor, or "aA" factor, as including the kind and degree of severity of the disability experienced by the child, and the child's gender and age. The family's perceptions of their internal resources for meeting the crisis, or "bB" factors, may include the family power structure, emotional bonding, communication patterns, values, characteristics of individual family members, and the family's balance between closeness and independence of its members. External family resources include social support from relatives, friends and social services and the ability to develop supportive and satisfying social networks. Just as important as the previous factors are the meanings that the family makes from having a disabled member, or the "cC" factor. Each family develops meaning for their experiences over time that are based on their personal experiences, colored by socioeconomic and cultural issues.

For Patterson, McCubbin, and others, the model of stress evolved into a model of coping, emphasizing the resiliency factors in most families that help them normalize and adapt to crises (Turnbull et al., 1993). Turnbull and her colleagues (1993) published a collection of conference presentations of families' stories of positive adaptation. Many of them were written by researchers who were also parents of children with disabilities. An important concept that has emerged is that of family coherence and congruency (McCubbin, Thompson, Thompson, & McCubbin, 1993), or the ability of the family to change its patterns of functioning in a positive way through re-appraisal or meaning-making.

Families from Diverse Cultures

All of the studies on families' reactions to disability reviewed so far were written under the implicit assumption that their findings applied to a homogeneous culture. Sensitivity to cultural and linguistic diversity has become a focus of special education only in the last few decades. Recently, a number of researchers have used stress and coping models to identify how they vary among different racial, cultural and linguistic populations. Blacher, Lopez, Shapiro, and Fusco (1997) studied Latino mothers from Central America and Mexico. They found that Latina mothers with children with mental retardation were more likely to have very high rates of self-reported depression scores on the Center for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977). They confirmed previous studies that Latina mothers in general score significantly higher than the normative group on this scale, which was normed primarily on Non-Hispanic White subjects (Radloff, 1977). However, the strongest predictor of depression was the mother's physical health. They noted that 40% of the Latina mothers of children with mental retardation had no spouse or partner, and that many of those who did said that their spouse had rejected them because of the child. They speculated that having a child with a disability may isolate Latinas from the "familismo" or strong identification within the family that is valued by Latinos.

Magana, Schwartz, Rubert and Szapocznik (2006) studied Latino families caring for adult children with severe mental retardation at home to clarify how children's maladaptive behaviors were related to family caregiving burden, relationship problems,

and family members' physical and mental health. They were interested in studying caregiving burden as a family problem in light of the theory that Latino families place more importance on how caring for a member with disabilities affects the whole family. They found that maladaptive behavior alone accounted for only a small portion of the difficulty in family relationships. Psychological stress of caregivers was associated with poor physical health. They speculated that poor health may add to the caregiver's burden of not being able to fulfill her family role of caring for the member with disabilities.

Heller, Markwardt, Rowitz and Farber (1994) studied Latino and non-Hispanic White families' formal and informal supports in caring for a family member with mental retardation to extend understanding of how cultural values affect adaptation. They found that SES had greater effects than race on the kinds of support families had. Latino families differed in their belief that taking care of family members with disabilities was a religious duty and religion gave meaning to the existence of disability in the family. Latino families also expressed less caregiving burden because of high family support. Caregiving burden was increased, however, by greater difficulties in accessing the service system, particularly in obtaining information about child development and in attending parent programs. Results were confounded by a high proportion of immigrants and wide variety of nationalities and cultures among their Latino subjects.

Rogers-Dulan (1998) studied the influence of a variety of religious experiences on the support networks of female African American caregivers who had children with disabilities. A significant negative relationship with depression measured on the CES-D was found for women who practiced religion in their personal and family life and felt

supported by their church. Religion played a role in coping with their challenges, providing meaning and ethics, and supported hope and positive self-talk. The study was limited to urban women with low SES.

Research in the adaptation of families of different cultural and ethnic heritages is still undeveloped (Hodapp & Burack, 2006), but has added to the field's sensitivity to the differing kinds of support families need from services. In the field of EI/ECSE, efforts to increase sensitivity to diverse cultures have included efforts to design cultural competencies for the largely white, middle class work force, as well as diversifying that workforce (Hanson & Lynch, 2004). Differences in values, biases, and strongly-held beliefs between providers and families can interfere with their relationships and the effectiveness of intervention (Carlson & Harwood, 2000).

Depression

Singer (1993) found in his work with caregivers of children with disabilities that a large majority were able to cope well and normalize their family functioning. Yet about 30% of parents who requested help from his programs were "feeling demoralized" or had more severe stress which required specialized intervention (Singer, 1993, p. 208).

Demoralization included feelings associated with depression, such as a sense of hopelessness and discouragement and lack of enjoyment in life. Singer and his colleagues developed an array of resources for parents that included training to control children's challenging behaviors, information, stress management, and respite. Stress management helped parents develop coping skills such as "self-monitoring of stressors, progressive

muscle relaxation, monitoring and expanding social support, using relaxation in natural settings, covert rehearsal for stressful situations, cognitive reframing, increasing pleasant activities, and time management” (Singer, 1993, p. 209). Singer and his colleagues found that this combination of interventions was beneficial to many parents, but that a smaller number of parents needed more individual counseling and in-home assistance. Their increased distress was associated with four kinds of severe, chronic stress, including “1) severe depression, 2) severe marital discord, 3) severe child problem behaviors, and 4) abuse and neglect of children in multi-problem families” (Singer, 1993, p. 210). Singer and his colleagues linked debilitating depression to many factors, including parents’ perceptions of their roles as parents, their relationship to their spouse, the severity of their child’s maladaptive behavior, and that individual families need different levels and kinds of support. When he attempted to disseminate his work, Singer realized that there weren’t enough trained counselors or social workers to fill the need.

Parents of children with disabilities have been found to experience depression at a higher rate than the general population. In a meta-analysis of studies which compared depression rates between mothers with and without children with developmental disabilities, Singer (2006) found an elevated risk in mothers of children with disabilities. He analyzed studies from 1982 to 2003 that employed self-reported depression on the CES-D (Radloff, 1977) or clinically diagnosed depression on the Beck Depression Inventory (Beck, 1993). He found an average effect size of 29% among mothers with children with developmental disabilities compared to 19% in comparison groups. Singer noted that epidemiological studies of all women of child-bearing age in the U.S. have

identified a rate of depression of about 20%. He also noted that reports of the incidence of depression among mothers of children of developmental disabilities didn't change over time, despite the development of universal special education and improved medical services since 1982.

Maternal depressive symptoms, whether they are self-reported or clinically diagnosed, have been repeatedly found to be linked to poor developmental outcomes in young children (Downey & Coyne, 1990). Maternal depression is considered a serious public health problem (National Institute on Child Health and Human Development Early Child Care Research Network [NICHD], 1999; Singer, 2006).

Depression is a recurring, episodic disorder that takes many forms. Depressed mothers have mood dysregulation, with prolonged sadness and/or inability to experience pleasure (Zahn-Waxler, Duggal & Gruber, 2002). Vegetative disturbances affect energy level, eating and sleeping. Cognitive impairment includes difficulty with concentration and distortions in thinking. Psychological effects include loss of self-esteem, irritability and loss of interest in social interaction (Zahn-Waxler, Duggal & Gruber, 2002).

Depression may be particularly damaging to parent-child interactions when it is chronic, because it exposes the developing child to a longer period of unsupportive or negative interactions with the primary caregiver (NICHD, 1999). Particularly affected are the social and emotional, cognitive and language domains of development in the young child because these depend so heavily on close relationships with caregivers in early development (Downey & Coyne, 1990).

One important characteristic of depression is its co-morbidity with other mental illnesses, particularly anxiety and personality disorders, which have their own adverse affects on child development (Seifer, 1995). The social context of depression is also important. People with depression often choose partners who also have a psychiatric illness or a family history of mental illness, aggravating their own symptoms and adding to family disturbance (Downey & Coyne, 1990).

As many studies have shown, the adverse life conditions of people with depression and other psychological disorders, and the inability to protect children from multiple risks are associated more with poor outcomes for children than having a depressed parent alone (Seifer, Sameroff, Baldwin & Baldwin, 1992). In a national sample of 1,200 mothers and children, the NICHD (1999) identified 38% of their sample as sometimes depressed, and 7.5% as chronically depressed from self-ratings on the CES-D. Their longitudinal results over the children's first three years indicated a relationship between income-to-needs ratio and maternal sensitivity. In other words, women who were chronically depressed, but had higher income-to-needs ratio were more sensitive. The NICHD study found that maternal sensitivity was an important factor in children's development. Children of mothers who were more sensitive performed better on cognitive and language tests even when their mothers were chronically depressed.

These findings support the theory that depression is complicated and its effects on children are mediated by many factors (Downey & Coyne, 1990). The effects of parental depression may be heightened when the family is experiencing other risk factors such as financial insufficiency or instability, isolation, and domestic violence. These risk factors

are commonly correlated with depression, and may heighten the effects of parental depression on children by reducing the mother's energy and sensitivity for caretaking (Kelly & Barnard, 2000; NICHD, 1999).

Many research findings have contributed to the understanding of parent-child interaction when maternal depression is present. Attachment theory in particular has provided a framework for understanding how parent-child interaction may fail to support the healthy social-emotional development of young children (DeMulder & Radke-Yarrow, 1991). Children's attachment patterns are formed over time through experience-dependent expectations of how available and responsive caregiving will be.

Temperament, psychological functioning, past experience, and cultural and familial interaction patterns all contribute to its development (DeMulder & Radke-Yarrow, 1991). There is considerable evidence supporting a higher proportion of insecure attachment in families with maternal depression (Zahn-Waxler, Duggal & Gruber, 2002).

Caregivers who are unavailable, inconsistent or even rejecting have children who form expectations that it is useless to turn to caregivers in times of stress (Keller, Spieker & Gilchrist, 2005). Insecure attachment is not considered a sign of pathology, but is seen as a risk or protective factor in the context of other risks. Keller and colleagues (2005) identified a pattern of maternal perception of the infant as negative and difficult (i.e., fussy, irritable, prone to distress) combined with the quality of insecure attachment that was associated with the baby's high levels of externalizing behavior. This pattern was consistent even in families who had adequate resources. Children with attachment characterized as avoidant had more than three times the risk of developing challenging

behavior. Avoidant attachment develops in relationships in which the child learns to anticipate and expect hostility and rejection (Keller et al., 2005).

The difficulty of chronically depressed mothers in controlling their own negative behavior when upset is associated with the likelihood that their infants will be more difficult and dysregulated (Zahn-Waxler, Duggal & Gruber, 2002). This is of particular concern in the case of infants with disabilities. Infants who are born prematurely, who have sensory overreactivity, or whose hard-to-read cues make them difficult for parents to soothe could have negative characteristics that make them more vulnerable (Greenspan & Wieder, 1998; Sameroff & Chandler, 1975).

Summary

Disruptions in the social-emotional development of children with disabilities, which in extreme cases includes experience of abuse and neglect from their families, can lead to serious behavior problems and mental health disorders (Garbarino, 1989). The field of EI/ECSE has until recently neglected to focus specifically on the vulnerability of children with disabilities to developing mental health problems (Knitzer, 2000). Healthy emotional development is intimately connected to the child and family context (Zeanah, 2000). Service providers in EI/ECSE need to develop skills in supporting families' nurturance of their children's emotional development. This will require collaboration between the fields of disability and mental health (Kaufmann & Hepburn, 2007).

Purpose of the Study and Research Questions

There are currently no published research studies on how EI/ECSE service providers in Oregon are working to address the mental health problems of the children and families they serve. A descriptive study to identify how EI/ECSE agencies in Oregon perceive the mental health needs of children and families, what strategies they have used to address these needs, and what further changes are needed in services is needed to fill this gap. To guide an exploratory study of these issues in Oregon, the following research questions will be followed.

1. How do EI/ECSE agencies describe the mental health needs in children and families they serve?
2. How do EI/ECSE agency personnel describe the ability of their own personnel to understand and support children's social-emotional development?
3. How do EI/ECSE agency personnel describe the ability of their own personnel to understand and support the mental health needs of families they serve?
4. How do EI/ECSE agency personnel describe the ability of their community to meet the mental health needs of children and families they serve?
5. How do mental health agency personnel describe the ability of their community to meet the mental health needs of children and families served by EI/ECSE agencies?
6. What recommendations do EI/ECSE and mental health agency personnel make about improving services to support children's social-emotional development and the mental health needs of families they serve?

CHAPTER II

REVIEW OF LITERATURE

In light of the mental health needs of children and families served by EI/ECSE programs, this chapter will examine the literature on how EI/ECSE programs have approached this issue. Programs that serve young children with disabilities can make a significant contribution to the emotional well-being of children and families, yet young children with disabilities who have social-emotional problems are under-identified and rarely receive mental health services (Knitzer, 2000; Severson & Walker, 2002). The field of EI/ECSE has a long history of interest and experience in supporting families (Bowe, 2004), but like other professionals in early childhood, EI/ECSE providers have had little training and experience in working with more acute mental health needs in parents or children, or what is associated with early childhood mental health (Knitzer, 2000). EI/ECSE providers find themselves increasingly faced with these issues. A large proportion of families served by EI/ECSE are of low socio-economic status (Hebbeler et al., 2001), and a significant proportion bring with them the many mental health issues associated with difficult life circumstances (Bricker, 1989; Downey & Coyne, 1990).

In parallel to the needs of EI/ECSE, programs in the larger field of early childhood, particularly Head Start, have been attempting to reform services for children and families with mental health needs. Head Start and ECSE serve an overlapping population of children who come from multi-risk, low-income families. Head Start is

required by its federal mandate to include at least 10% of children with disabilities in its preschools; some Head Starts in Oregon serve a much higher proportion (C. Snead, personal communication, January 24, 2006). Head Start has been attempting to respond to an increasing number of children with challenging behavior and families who are suffering from depression, substance abuse and family violence (Yoshikawa & Knitzer, 1997). Researchers in the early childhood mental health field, particularly in Head Start sites, have identified two important issues: a) a mental health system that is both accessible to families with young children and that has providers who specialize in the early childhood needs to be developed to provide treatment to this population; and b) all personnel working with young children (i.e., early childhood, EI/ECSE, child welfare) need to improve their skills in supporting parent-child relationships, promoting children's early social-emotional development, and in identifying and referring children and families who need mental health support (Fenichel, 1992; Knitzer, 2000). The field of early childhood mental health includes concern for young children and families at risk; there is a strong emphasis on prevention (Knitzer, 2000; Zeanah, Larrieu & Zeanah, 2000).

Knitzer (2000) has identified a set of core services that should be available to families, particularly children who are at high risk for developing mental health disorders (2000). These include a) integrating mental health principles into the core program; b) adding on-site mental health staff to provide clinical supervision within programs; c) providing on-site ongoing consultation by mental health staff trained in early childhood; and d) providing mental health treatment in non-traditional settings where families and

children have their normal activities (i.e., in the classroom or in the home). These strategies require early childhood practitioners to partner with those in mental health areas for training and facilitating access to mental health services (Knitzer, 2000).

Before describing the literature on work in early childhood mental health, however, it is necessary first to describe the EI/ECSE and child mental health systems. This will provide a background for understanding how these two systems could partner in Oregon to serve the mental health needs of children with disabilities and their families.

EI/ECSE Services in Oregon

Young children under school age in the U.S. who have significant disabilities receive special education under a federal EI/ECSE system established by P.L. 99-457 in 1986. States provide EI services for children from birth through their third birthday through Part C of the Individuals with Disabilities Education Act (IDEA), and ECSE services for children from age three until they enter elementary school through Section 619 of Part B. Part B also covers laws for children 6-21 with disabilities, and ECSE services are provided by local education agencies as part of the school-age special education system.

Oregon EI/ECSE serves approximately 2,500 children birth to three and 6,000 children in the three to school-age range (N. Johnson-Dorn, personal communication, October 12, 2007). The responsibility for the administration of the EI/ECSE system for children with disabilities birth to school age in Oregon lies with the Oregon Department of Education (ODE). ODE contracts with 9 regional education service districts that

provide EI/ECSE services in 33 local programs associated with counties. Oregon has a “seamless system” in the sense that it serves Part C and Part B in the same state agency, and requires an Individualized Family Service Plan (IFSP) for the whole age range of birth to school age (Oregon Department of Education, Office of Student Learning and Partnerships, 2007). Many other states differ from Oregon in that they designed their systems so that Part C and Part B are administered under separate state agencies (Bowe, 2004).

Eligibility for EI/ECSE Services

Each county in Oregon has a designated referral and education agency, which is the responsibility of EI/ECSE agencies in each county (Oregon Department of Education, EI/ECSE Services in Oregon, 2007). The local EI/ECSE agency and school district have responsibility for locating and evaluating children birth to five years who may be eligible for EI/ECSE. The local school district is solely financially and legally responsible for eligibility evaluations, and may contract with another entity, such as the local EI/ECSE agency, to do the evaluations (Region 3 EI/ECSE, 2003).

The process for evaluating children for eligibility in Oregon varies between counties depending on staffing and budget constraints, but the general procedures are set by Oregon law and interpreted through Oregon Administration Rules (OAR) and guidelines from the Oregon Department of Education (Region 3 EI/ECSE, 2003).

Although children in EI and ECSE are served by the same agency in Oregon, eligibility for EI and ECSE have different requirements based in federal law.

Early intervention. For EI eligibility, there are three ways a child may become eligible. First, the child may qualify under five categorical areas of eligibility (i.e., autism spectrum disorder, deafblindness, hearing impairment, orthopedic impairment, and visual impairment). Second, a physician may document that the child has a diagnosed physical or mental condition likely to result in developmental delay. Third, the child is determined to have a developmental delay of 2 standard deviations below the mean in one area of development, or 1.5 standard deviations below the mean in two developmental areas as indicated by standardized testing, and as a result needs EI services (OAR 581-015-0946). The EI evaluating team must be composed of at least two disciplines or professions and eligibility must be based on informed clinical opinion. Assessment is conducted in all five areas of development, including cognitive, physical, communication, adaptive, and social or emotional development (OAR 581-015-0945) (Region 3 EI/ECSE, 2003).

Early childhood special education. For ECSE eligibility, there are two ways a child may become eligible. First, the child may qualify under 11 categorical disabilities (i.e., the five categorical disabilities included in EI, plus communication disorder, emotional disturbance, mental retardation, other health impaired, specific learning disability, and traumatic brain injury). Second, the child may qualify as having a developmental delay if he or she receives a score of 1.5 standard deviations or more below the mean in two or more developmental areas (Region 3 EI/ECSE, 2003).

Eligibility determination. When children in the community are identified as having a potential developmental problem, they are referred for evaluation to see if they meet the state eligibility requirements for EI/ECSE services. The federal government

allows states flexibility in how they identify children with disabilities (Bowe, 2004). When writing its eligibility laws, Oregon's legislature opted for somewhat more restrictive eligibility standards and not to serve the population of children at risk (E. Twombly, personal communication, July 7, 2007). Eligibility evaluation includes gathering information on children through testing, observation, developmental histories and parent interviews. Information is often gathered from referral sources other than the family, such as the physician or preschool, with family permission. Eligibility determination occurs prior to entry into the EI/ECSE program, and also at two other points during the child's enrollment in the program. For children already enrolled in EI, a second eligibility determination is conducted before their 3rd birthday to see if they meet eligibility requirements for ECSE services; for children in ECSE nearing kindergarten transition, those who have eligibility under "developmental delay" are evaluated for categorical special education eligibility. Children transitioning from ECSE to kindergarten are not guaranteed special education services in elementary school, but must qualify under school age eligibility requirements (Region 3 EI/ECSE, 2003).

Social or emotional delay or emotional disturbance. In terms of eligibility, the social or emotional area of development refers to the child's reactions to self and others, interest in play materials, and affect (Region 3 EI/ECSE, 2003). In Oregon, children may qualify for EI/ECSE services through developmental delay in the social or emotional area by receiving a score of 2 standard deviations below the mean on a standardized assessment. In EI, they may also qualify if they score 1.5 standard deviations below the

mean in the social-emotional domain if they also qualify in another developmental area (Region 3 EI/ECSE, 2003).

After age 3, a child may qualify for the ECSE categorical disability of emotional disturbance. To qualify, the child must have been experiencing an extreme emotional or behavioral problem for a long period of time, usually at least six months, that carries over into different environments (e.g., home, childcare), and that affects the child's ability to learn and establish friendships with peers (Region 3 EI/ECSE, 2003). It is difficult to apply the category of emotional disturbance to a young child because of the variability of the early childhood developmental period and children's sensitivity to their environments. Temporary emotional problems may occur due to health factors, unsupportive or poor quality childcare, and traumatic events that are of short duration. Cultural norms also add to the difficulty of identifying behavior that qualifies children for services (Region 3 EI/ECSE, 2003). If children do not qualify for services under the category of emotional disturbance, they may meet the criteria of developmental delay in areas affected by emotional and behavioral problems, which include social, adaptive, communication, and cognitive areas (Region 3 EI/ECSE, 2003).

A Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 2000) diagnosis is not needed to qualify a child for EI/ECSE services under the emotional disturbance label. Federal special education law has its own criteria for eligibility under this category, which are independent of the criteria used to diagnose children in the mental health system (Riccio & Hughes, 2001). Under federal law, children can receive psychological services in EI/ECSE as related services if they

are necessary to support the child's educational progress. Psychological services can be provided in a variety of modes, including consultation to the teacher or home visitor, direct treatment, and parent training (Riccio & Hughes, 2001).

Issues related to the use of the emotional disturbance category. Nationally, very few children in EI/ECSE programs qualify for services solely under the category of emotional disturbance or social-emotional delay. The NEILS longitudinal study (Hebbeler et al., 2001) found that programs for children age birth to three reported that only 3.7% of children received services under this category, with a mean age of 22 months (Hebbeler et al., 2001). For children receiving special education preschool services in the 3 to 5 age range, only 1.4% were reported as being served for an emotional disturbance in U.S. Department of Education data in 2000-2001 (Powell, Fixsen, Dunlap, Smith & Fox, 2007). This percentage for preschool-age children may not have included children with social-emotional delays, which is not reported separately from general developmental delay (Powell et al., 2007). In Oregon, a small number of children become eligible for EI/ECSE services with a developmental delay in the social area via clinical judgment (G. Morgan, personal communication, May 5, 2007).

The eligibility requirements for the emotional disturbance category have been criticized for being inappropriate for the early childhood period (Conroy & Brown, 2004). Because serious behavior problems become more intractable the longer they are left untreated (Severson & Walker, 2002), eligibility guidelines that require the problem to have "existed over an extended period of time," typically longer than six months (Region 3 EI/ECSE, 2003) is not seen as assisting early identification (Conroy & Brown,

2004). The requirement that behavior has “an adverse impact on the child’s educational performance” (Region 3 EI/ECSE, 2003) is difficult to apply to a child under age 5. Some states have modified their EI eligibility for social or emotional delays in order to serve children earlier. For example, for children who do not meet other eligibility criteria, Maryland uses an eligibility category of atypical development in the social/emotional area to make children eligible for services (Steele, 1998). It is likely that EI/ECSE programs will need to modify eligibility requirements in order to get children with serious social-emotional disturbances into services early (Conroy & Brown, 2004; Gilkerson & Kopel, 2005; Steele, 1998). Speculation about why more children are not identified for services under the emotional disturbance category include not only problems in how eligibility is determined, but also the wish to protect children from a stigmatizing label, the high cost of services when they are identified, and the dearth of adequate mental health treatment services for children (Conroy & Brown, 2004; Severson & Walker, 2002).

Mental Health Services for Children

The publication of Knitzer’s *Unclaimed Children* by the Children’s Defense Fund in 1982 helped to focus national attention on the lack of coordinated, community-based mental health services for children and their families, and influenced state mental health systems to begin improving services for children (Kutash & Rivera, 1996). At that time, children with serious emotional and behavioral disorders and their families were identified as a service priority for the public mental health system (Friedman, 2001). Led

by a federal initiative from the National Institute on Mental Health (NIMH) in the mid-1980s (Stroul & Friedman, 1986), state mental health services for children and adolescents with serious emotional and behavioral disorders began planning and developing comprehensive, community-based systems of care. This effort continues to the present (Friedman, 2001; Knitzer 1993; Kutash & Rivera, 1996; Perry, Kaufmann & Knitzer, 2007). The NIMH federal initiative proposed a system of care model in which mental health services are available in a continuum of least to most restrictive settings, coordinated through case management and multidisciplinary teams, with services delivered in a culturally competent manner, and including promotion of family involvement in treatment planning and support for family advocacy (Stroul & Friedman, 1986). The goal of systems of care is to provide the least restrictive level of support so that children with serious emotional disorders can remain in the community as much as possible, preferably with their families, with a well-coordinated, interrelated system of services that children can move through as they need them (Friedman, 2001; Stroul & Friedman, 1986).

Residential treatment centers for children with severe emotional and behavioral problems have been at the center of controversy since the late 1980s because of the large numbers of children placed in these highly restrictive settings. Public policy has shifted more toward developing services to keep children in the community (Knitzer, 1993). An important impetus for the development of a mental health system that provides community services on a continuum is the reduction of costs, as the most restrictive placements are also the most expensive.

Kutash and Rivera (1996) provided a description of the types of services that compose comprehensive systems of care and a history of their development. Crisis or emergency services are provided by the community to help families resolve crisis situations and divert placement of children in costly hospital or residential settings. They serve families that are usually functioning well, but have occasional crises, as well as families with children who have chronic mental health problems with acute crises. Non-residential crisis services include phone lines and mobile outreach; residential crisis services include runaway shelters, foster homes, and hospital crisis stabilization units.

Mental health outpatient services or therapy are usually the initial mental health services used by children and their families, and are also the most frequently used. They are available from both public community mental health and private providers and from hospitals, and can be provided by a wide range of personnel, including social workers, counselors, psychologists and psychiatrists.

Day treatment is a form of intensive non-residential treatment that serves children who have a range of needs from severe emotional disorders to developmental delays, with a goal of reintegration into the community. Children spend at least 5 hours/day involved in educational and counseling interventions, and family interventions are also provided. They are usually staffed through a collaboration of special education and mental health personnel.

Family preservation services were first developed in the 1970s. They are short-term (i.e., 1-3 months), intensive crisis intervention services that take place in the home. They are used for children who are at imminent risk of placement in a more restrictive

setting when child welfare or juvenile justice services are involved, and are used when other interventions have been unsuccessful. Services include increasing family coping skills, counseling, child and parent skill training, and connection to community resources.

Therapeutic foster care, developed in the mid 1980s, is considered the least restrictive residential placement for children with serious emotional disorders needing out-of-home care. The child lives in a home with trained foster parents until he/she can move to a less restrictive placement. It may be used as part of transition from residential treatment.

Inpatient hospitalization and residential treatment centers are the most restrictive placements for children with serious mental health problems. Psychiatric hospitalization is used for acute crises or for ongoing problems that are difficult to treat. An alternative to psychiatric hospitalization is placement in a residential treatment center, providing 24-hour care.

Unfortunately, most states and communities are still in the planning stages of flexible and comprehensive systems of care (Kaufmann & Hepburn, 2007). Many communities have portions of the system of care, such as day treatment and family preservation services, but lack services in other areas, such as adequate crisis services (Kutash & Rivera, 1996). In addition, services in childhood mental health have focused on school-age children, particularly adolescents (Meyer, 2007). There is a critical shortage in mental health personnel who have expertise in the social-emotional development of infants, toddlers, and young children under age 5 (Meyer, 2007).

Only a small proportion of children who need mental health services ever receive them (Mrazek & Haggerty, 1994). The National Institutes of Medicine estimate that only about 20% of children who have emotional disorders receive mental health services (Mrazek & Haggerty, 1994). Kaufmann and Hepburn (2007) argue that this must be remedied by infusing mental health services and supports into programs that are already being used by young children and families. This effort calls for collaboration across systems of early childcare, special education, mental health and child welfare to identify vulnerable families for preventive and early intervention services (Kaufmann and Hepburn, 2007).

Prevention and Early Intervention for Mental Health Problems

Children's mental health services for acute disorders are costly and do not come near to meeting the need (Knitzer, 2000). Many researchers argue that children's mental health problems are better dealt with through early identification of risk, and through early intervention before children develop serious mental health problems (Knitzer, 1993; Severson & Walker, 2002). Severson and Walker (2002) lament that few children receive intervention at an early age, even though research over the last 25 years has consistently identified the behavioral and family risk factors for serious social and behavioral disorders, and there are well-studied models of the developmental trajectory of behavior problems from early childhood to adolescence (e.g., Kazdin, 1995).

Most children who receive mental health services are served in schools (Webster-Stratton, 2002). However, children with emotional disturbance are not identified for

special education services until their problem behaviors are well established (Severson & Walker, 2002). On average, their first special education services start around age 8, even though parents report their difficulties started before age 5 (Wagner, Kutash, Duchnowski, Epstein, & Sumi, 2005).

Behavioral Support

When children are identified with behavior problems in EI/ECSE programs, the initial kinds of treatment are often behavioral (Wolery, 2000), with the treatment goal being a reduction of problem behaviors (Nickel, 2000). EI/ECSE programs sometimes offer families behavior management information and training to help them develop skills in child discipline (e.g., Gilkerson & Kopel, 2005). Programs have also been invested in development of staff with expertise in behavioral interventions focused on the preschool population. Wolery (2000) described recommended practices followed by behavioral consultants or EI/ECSE specialists who are called in to help classroom teachers and families with challenging behavior problems. A functional assessment is conducted to identify the specific communicative or social function of a particular child's problem behaviors (e.g., escaping from something unpleasant, or attempting to gain attention). The observation of the events around the occurrence of the behavior (i.e., antecedent events), the behavior itself, and the consequences of the behavior are analyzed to identify the purpose of the behavior. Treatment consists of teaching strategies to child care providers, families, and other caregivers. A wide range of strategies are available, including changing the environment in which behavior problems are occurring, building

skills in the child where deficits are apparent, providing more choice and control to the child, and teaching alternative communicative behaviors (Wolery, 2000). Head Start classrooms and other community child care providers that partner with EI/ECSE to place children with disabilities benefit from the expertise of EI/ECSE personnel who have developed behavior treatment skills (G. Morgan, personal communication, May 20, 2007).

Interest in universal behavioral strategies that are applied to all children in center-based settings has been gaining momentum, particularly in programs that serve children at risk or with disabilities, such as Head Start and EI/ECSE programs. The Center on the Social and Emotional Foundations for Early Learning [CSEFEL] (2007) was established with federal dollars from Head Start and the Child Care Bureau of the U.S. Department of Health and Human Services. Its purpose is to design and disseminate a research-based training program for programs serving low-income children to work with behavioral challenges. This program focuses on establishing a positive emotional climate in the classroom, teaching children the skills they need to be successful, and teaching teachers and other caregivers self-reflection and assessment skills to modify their thinking and behaviors (CSEFEL, 2007). It has been promoted in the state of Oregon by the Oregon Department of Education, which is collecting data on pilot sites in Head Start and EI/ECSE preschools in all nine EI/ECSE regions in Oregon (J. Olson, personal communication, May 31, 2007). This program is currently available only for the preschool age range, although new modules are being development for the birth to three age range (CSEFEL, 2007).

Another promising strategy to build the capacity of early childhood programs for identifying and working with children before mental health problems develop is mental health consultation. There is a growing body of research on mental health consultation for general early childhood programs, and interest at the federal level for its dissemination as a recommended practice.

Mental Health Consultation in Early Childhood Programs

In response to reports from national experts that an increasing number of children with behavior problems are overwhelming child care providers, in 1998 the federal Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, in conjunction with the Georgetown University Center for Child and Human Development, convened a group of mental health professionals to write national guidelines for mental health consultation in early childhood care settings (Cohen & Kaufman, 2005). The technical assistance center at Georgetown University Center for Child & Human Development (called the National Technical Assistance Center for Children's Mental Health) was established in 1984 by NIMH as part of the federal initiative to improve the mental health service system for children and adolescents. Also established were research and training centers on children's mental health at Portland State University in Oregon and at the University of South Florida (Knitzer, 1993).

According to the SAMHSA publication (Cohen & Kaufmann, 2005), mental health consultants are an effective way for programs to work with children who are

exhibiting challenging behaviors and are at risk for developing mental health problems.

The goal of using a consultant is to infuse a mental health perspective into the early childhood program. This perspective is built on the belief that social and emotional development is facilitated by nurturing relationships, and promotes the following values:

- 1) Young children deserve caregiving environments that support their social-emotional well-being.
 - 2) All of the relationships with and around the child need to be considered in assessing and planning services.
 - 3) Families need to be full participants.
 - 4) Mental health services should be delivered by culturally competent personnel.
 - 5) Practices build on the strengths rather than the problems of child, family and staff
- (Cohen & Kaufmann, 2005).

The mental health consultant's role is to work with program staff to develop skills in identifying and working effectively with children who have social-emotional and behavioral problems, and to train staff to carry out interventions. Consultation can focus at the child or family level in working with staff on problems encountered with a specific child or family; and at the program level, on improving a program's overall quality and functioning by incorporating a mental health perspective.

Despite the promotion of mental health consultation at the federal level, there have been very few well-designed empirical studies on the practice. Brennan and her colleagues (2005) at the Research and Training Center on Family Support and Children's Mental Health at Portland State University conducted the first systematic review of

literature and located only 33 studies using empirical methods between 1985 and 2005. They concluded that the reports on outcomes were favorable but were hindered by numerous design flaws. Subsequently, Green, Everhart, Gordon and Gettman (2006) published a large, well-designed, peer-reviewed empirical study using random selection that was designed to investigate how mental health consultants work in the Head Start system. The study examined program-level consulting (i.e., working with program management and staff to improve overall quality in the programs' ability to serve children with challenging behaviors) in a national sample of 74 Head Start programs. The study investigated the characteristics of consultants, the activities they provided, and the quality of their interactions with program personnel in relationship to staff assessment of consultants' effectiveness in helping with children's behavior and staff support. The significant finding was that the most important variable in effectiveness and staff wellness was the positive relationship established between consultants and staff. Staff reported that consultants who were perceived as available and who worked collaboratively were the most helpful, even though the majority of programs reported that consultation occurred on average every other month, and consultants often served over 200 children.

Universal interventions, behavior management training, and mental health consultation to programs may work for many children, but for families that experience chronic maladaptive interaction patterns, a more integrated mental health approach may be needed, both to assess maladaptive parent-child interaction patterns and as a treatment option (Drotar & Sturm, 1991). This need is particularly urgent when children are very

young. The field of infant mental health is a recent addition to the mental health area and has been influential in advocating for integration of mental health services into all early childhood services (Fenichel, 1992).

Infant Mental Health

The field of infant mental health focuses primarily on the psychological aspects of pregnancy and birth, and the relationship of the caregiver and infant until the child is three years old. Research on infants since the second half of the 20th century has identified this period as particularly important for the influence of the social environment on child development, particularly on the infant's social behavior and subjective emotional life (Fitzgerald & Barton, 2000). The field often refers back to Winnicott (1964), a pediatrician and child psychoanalyst who observed that infant development always occurs within relationships (Fitzgerald & Barton, 2000). Since 1980, with the first international Congress of the World Association of Infant Mental Health, the infant mental health "movement" has become an increasingly well organized international force for educating communities about the importance of social-emotional development of the first three years of life, and has supported investigations in theory and clinical work in this period (Gautier, 2000).

The field of infant mental health has been influenced by the transactional model of development (Sameroff & Chandler, 1975; Sameroff & Fiese, 2000). This model has called attention to the profound way that child development is influenced by the family, through the quality of relationships that parents and children have with each other, built

up through daily transactions and negotiations (Mahoney, Spiker & Boyce, 1996; Sameroff & Chandler, 1975). Child development is shaped by dynamic interactions between the child's characteristics (i.e., variation in activity levels, responsiveness, threshold of sensory stimulation, negative affect, and ability to be calmed), the parents' characteristics (i.e., capabilities and life experiences, and unique patterns of interaction with their infants), and larger ecological influences (Seligman, 1988).

In infant mental health, development of the infant is conceptualized in "biobehavioral" or "biopsychosocial" terms (Seligman, 1988, p. 42). In other words, development is characterized by interaction among all the domains of development, including physical, cognitive, social-emotional and communication, all of which are nurtured and supported by the interaction of the child with his or her caregiving environment (Seligman, 1988; Sroufe, 1995). The infant is born with the capacity to interact with caregivers and evoke responses from them, and the caregiver-child dyad develop increasingly complex interaction patterns as the child grows and develops (Tronick, 1985). The child needs a predictable, organized and responsive caregiver who contains and regulates the baby's emotions and gives meaning to interactions (Seligman, 1988). Thus, infant development is seen as an interplay between physiological development, and regulation and stimulation from the environment.

Infant mental health treatments are needed when psychological issues related to the child, to the parent, or to their relationship interfere with the parent's ability to care for the child (Kalmanson & Seligman, 2006). Parents' own emotional reactions, many of which are below their awareness, may interfere with their ability to support their child's

development, and instead they may misread cues, withdraw, become angry, and attribute ill intent to their child's behaviors (Fraiberg, 1980). Parents' reactions can be particularly destructive when maladaptive childhood experiences impose themselves subconsciously on parents' relationships with their infants (Fraiberg, 1980; Hirshberg, 1996; Seligman, 1988).

The importance of relationships in emotional development has led infant mental health theorists to propose that all work with young children and their families should not be focused on the child or parent, but on their relationship, and the relationship of the provider with the family (Bernstein, Campbell & Akers, 2001; Kalmanson & Seligman, 2006). Working with parents in ways that create a positive emotional experience is a core element of the therapeutic process in infant mental health (Kalmanson & Seligman, 2006). Direct-service providers are trained to model supportive, nurturing relationships with parents in order to support changes in parents' relationships with their children, in what is called parallel process (Bernstein, Campbell & Akers, 2001). Advocacy for a more relationship-focused kind of work influenced by infant mental health has been occurring in early intervention for many years (Seligman, 1988; Weston, Ivins, Heffron, & Sweet, 1997).

Summary

Concern for the psychological development of young children and their families has stimulated the development of many strategies in both the EI/ECSE and mental health fields, from prevention to comprehensive systems of care. Efforts to support the

mental health of vulnerable populations needs to be collaborative, across systems and disciplines, to provide a continuum of prevention, identification, and intervention services (Guralnick, 2005). Many advocates in the mental health field argue that the best way to do this is to infuse mental health supports into early childhood environments where children are receiving services (Kaufmann & Hepburn, 2007). Some programs in EI/ECSE have incorporated aspects of mental health practices into their services. Evidence for the extent and types of changes that have occurred toward building a more integrated system will be examined next.

Mental Health Supports in the EI/ECSE System

The creators of the federal EI/ECSE programs recognized that children birth to three have very different needs from preschool-age children and their families (Bowe, 2004). While Part B ECSE services are aligned with school-age special education in their focus on instructional services for children, Part C EI services were designed to provide supports for families to care for their infant or toddler and emphasize service coordination rather than child-centered instruction (Bowe, 2004). The creation of an IFSP as a working contract with families that was required by P.L. 99-457 identified the family, instead of the child, as the recipient services, and has challenged the field to serve the child through the family context (Slentz & Bricker, 1992). The guiding principles for practitioners to work with families that have been promoted by the Division for Early Childhood of the Council for Exceptional Children, the EI/ECSE national professional association, include the following four themes:

- 1) Families and professionals share responsibility and work collaboratively;
- 2) Practices strengthen family functioning;
- 3) Practices are individualized and flexible; and
- 4) Practices are strengths- and assets-based (Sandall, McLean & Smith, 2000, p. 45-46).

These guiding principles are based on the conception of the role of families in P.L. 99-457 as active decision makers in determining priorities for and planning services, and identifying resources they needed to support their child (Bowe, 2004; Dunst, Trivette & Deal, 1994). The competencies that are required of EI/ECSE providers in order to work in a family-centered system have been addressed in the personnel preparation literature since the initiation of EI/ECSE services (Winton, McCollum & Catlett, 1997). Klein and Gilkerson (2000) include among them the competence of understanding concerns and preferences from the family's point of view in ways that identify parents' and children's competence and strengths. Providers must be prepared to design intervention so that it can be incorporated in the individual communication and problem-solving style of a family. Klein and Gilkerson argue that competence in self-knowledge is also required by professionals. Self-knowledge is needed to develop the skill to distinguish providers' own goals and motivations from those of families, and to work in the non-hierarchical and non-judgmental fashion necessary to develop partnerships with families (Klein & Gilkerson, 2000).

The influence of the transactional model of development (Sameroff & Fiese, 2000) on the field of EI/ECSE supports a focus on parent-child relationships through its

perspective that parents have the primary influence on their children's development and that the parent-child relationship can be a medium through which the trajectory of child development can be improved (Mahoney, Spiker & Boyce, 1996). In EI/ECSE work, social-emotional development can be overlooked when parents and providers focus on the child's physical and health needs (Seligman, 1988). Training providers to focus on the affective interactions in the parent-child relationship is supportive of early emotional development (Kalmanson & Seligman, 2006).

The field of EI/ECSE has had an ongoing debate about the compatibility of assessment and intervention of the parent-child relationship with its philosophy of family-centered services (Gilkerson & Stott, 2000). The issues raised include how to include the family in situations in which it is suspected that the family has maladaptive interactions; to what extent the subjective judgment of EI/ECSE professionals colors their assessment about which families are "good" or "bad;" whether cultural misunderstandings and disagreements over beliefs and values about child rearing practices can be prevented from entering into assessments and interventions; and how assessment of parent-child relationships might affect the building of trust and respect between families and EI/ECSE professionals (Baird & Peterson, 1997; Mahoney, Spiker & Boyce, 1996). If programs decide to use parent-child interaction assessment, the validity of instruments to assess parent-child interactions, and the experience of EI/ECSE professionals in a process that requires specialized clinical skill and sensitivity are also called into question (Mahoney, Spiker & Boyce, 1996).

Gilkerson and Stott (2000) suggest that two perspectives have been used in EI/ECSE related to supporting parent-child relationships. One perspective, which they identify as working “through the relationship,” focuses on changing external parent-child interactive behaviors, with the goal of increasing families’ competence and understanding of the importance of their own roles in supporting their child’s development. The second perspective, working “with the relationship,” focuses on the internal or subjective experiences of the child, parent, and provider, while also working on their relationship (p. 463-464).

Working Through the Relationship

McCollum & and Yates (1994) presented a model for working “through the relationship” with the parent-child interaction as the primary focus of intervention. The interventionist works through an “intervention triad” (p. 55) composed of the parent, child, and interventionist. In the case of infants with disabilities, the child may have responses to caregiving that are unusual or difficult for parents to interpret. When infants respond irritably or flatly, parents may feel rejected and over time fail to develop an empathic connection with their child (Kalmanson & Seligman, 2006). The McCollum and Yates model has a series of scaffolding strategies to build parents’ confidence and competence in interactions. Scaffolding, a term the field has borrowed from Vygotsky (Dixon, 2003), refers to the interventionist providing assistance at a level that allows the parent to perform slightly beyond her current level in a way that the parent still feels in control of her own learning. McCollum and Yates provide a continuum of concrete

strategies that range from simply designing an environment which encourages playful, positive interactions between the parent and child to modeling and telling the parent how to interact with the infant. Use of different strategies with different families depends on the interventionist's ability to think in the moment and to recognize the learning styles and cultural preferences of parents. McCollum and Yates (1994) recommend interventionists be supported with supervision to help them recognize how their own values and biases may affect how they interact with families.

Another example of working "through the relationship" can be seen in a study by Moss and Gotts (1997). They presented case studies of how an urban EI agency used a preventive parenting education curriculum to guide interventionists in supporting parent-child relationships. The curriculum, called Partners in Parenting Education (PIPE), is designed for parent educators to teach parents how to become more emotionally available to their babies and toddlers, read their child's emotional cues, and support their child's development of emotional regulation (How to Read Your Baby, 2007). Moss and Gotts reported on a formative evaluation of the first four months of using the new curriculum, and both served as clinical supervisors for the interventionists. Teen parents and parents with developmental disabilities were the recipients of services. The parent-completed questionnaire from PIPE provided a basis for interventionists to identify areas of concern in parent-child interactions and to initiate talk with parents about their understanding of their babies' feelings and behavior. Curriculum strategies included focusing on the parents' development of empathy and reading their babies' cues by coaching them in activities such as making a book of pictures of the baby's face in different emotional

states, creating objects that symbolized their love for their child, and talking with the parent about how their child was a separate person from themselves. Evaluation of the project found that the curriculum activities strengthened the working relationship between provider and parent. This in turn, increased the likelihood that the parent would follow through on the provider's suggestions for intervention activities with the child. Success in intervention increased providers' investment in working with parents and made the partnership a very positive experience for providers working in difficult situations. The curriculum supported the integration of family-centered services by focusing attention on the parent's ability to support their child's development, and away from the provider as the expert working with the child, with resulting improved outcomes for the child. The authors and interventionists concluded that regular reflective supervision provided during the formative evaluation was a necessary component to help interventionists understand family systems and make modifications in the curriculum to work with the EI population. Texas, where the study occurred, has subsequently initiated statewide training to increase EI/ECSE providers' knowledge of social-emotional development (Graham, White, Clarke & Adams, 2001).

Working with the Relationship

The second perspective of Gilkerson and Stott (2000) is practiced by EI/ECSE theorists and practitioners who have attempted to incorporate infant mental health practices into EI/ECSE, particularly into services for infants and toddlers (i.e., Part C). Some theorists would like to add elements of mental health practice, such as consultation,

to EI/ECSE services, while others argue for merging the two fields (see Foley & Hochman, 2006).

Weston, Ivins, Heffron and Sweet proposed a model in 1997 of integration of infant mental health and EI/ECSE. They argued that family-centered service delivery requires that EI/ECSE organizations focus on relationships as the organizer of service delivery. This requires changes in both the infrastructure of the organization and in how services are provided to families. They proposed that the skills to develop a relationship-based organization be brought into EI/ECSE from the field of infant mental health.

Weston and her colleagues (1997) summarized the processes necessary to support organizations to develop collaborative and therapeutic relationships with parents. They argued that practitioners' skills in observing and eliciting parents' perceptions of their children and of the emotional quality of the parent-child relationship need to be developed. Parents often have intense feelings about their child's disability and may need psychological support to understand how this interferes with caregiving (Seligman, 1988). Practitioners increase their objectivity in interpreting and understanding the emotional needs of parents through clinical supervision and using skills of self-reflection. The goal is to support parents in separating their own emotional distress from the developmental needs of the child (Hirshberg, 1996). Many of the skills that practitioners need come from the mental health field. These mental health skills are used to help parents and providers clarify and separate the emotional issues of parents to be recognize, understand and support the child (Weston et al., 1997).

Weston and her colleagues assert that in order to support practitioners in working with families, reorganization of EI/ECSE programs needs to occur. Staff time needs to be restructured to allow time for training and support in new skills through case staffings and ongoing, regular supervision. Both focus on developing objectivity and empathic listening skills. New sources of funding are often needed to support these fundamental changes in the organization (Weston et al., 1997).

Weston et al. (1997) argue that supervision is required of all staff in the organization, including managers, with the focus of developing supportive, collaborative relationships among staff and between management and staff. Building collaborative relationships within the organization fosters the parallel process of managers modeling supportive relationships with staff, who learn and model the same kind of relationships with parents. Parents in turn learn through this modeling to use nurturing and supportive relationships with their children (Weston et al., 1997).

Incorporation of Mental Health Models in EI/ECSE Systems

The attempts by Weston and her colleagues (1997) and others to bring infant mental health practices into EI/ECSE have been influential in state and local programs that have pursued the incorporation of mental health training and practices into their EI services (Klein & Gilkerson, 2000; Steele, 1998). Descriptions of program change in three states, Rhode Island, Maryland, and Illinois, will be presented. There is a limited literature on the design of actual EI/ECSE programs to accommodate families' mental health issues. For this reason, reporting on the descriptions of programs and outcomes of

system change will occur in some detail here in anticipation that these studies will help focus the present study. All of the systems change studies identified in the literature are on agencies that provide Part C-only services (i.e., services for infants and toddlers up to age three).

Rhode Island

Hirshberg (1998) described his experience as a mental health professional doing case consultation to an Early Intervention program in Rhode Island for four years. His primary purpose was to integrate an infant mental health perspective into the agency.

Hirshberg is of the opinion that service delivery in the home, working in the family context, makes EI/ECSE essentially a mental health field. Understanding parents' emotional experience, working with parents' resistance to change, witnessing and allying with family strengths to support change, are the core functions of a mental health professional, and Hirshberg believes they should also be practiced by EI/ECSE providers. He also argues that mental health evaluation and treatment should be available as a service option offered by all EI programs, just as other services such as speech and physical therapy are available.

To build these skills in EI professionals from a variety of disciplines (e.g., occupational and speech therapists, special educators), Hirshberg conducted monthly three-hour case consultations at the EI agency. At each session, several staff members presented a case on a child and family with which he or she sought help. Over time, staff

became more comfortable in exchanging perceptions about the cases and in talking about where they needed to strengthen their practice.

The object of the consultation was to help staff to improve their ability to see family strengths and ways to connect with them as partners. Hirshberg was particularly interested in nurturing skills that he wanted staff to use in their work with families. These included careful observation of what parents and infants experienced, and of the relationships between members of the family, and between the practitioner and family; helping staff learn to tolerate ambiguity during the reflection process when solutions were not immediately apparent; allowing staff to find their own creative solutions; encouraging them to examine how well or poorly the EI system accommodated the family; and building the capacity among practitioners to reflect on their inner thoughts and feelings about working with particular families.

Hirshberg (1998) found that over a period of time, the staff took over the group consultation process and outside consultation was not longer needed. Staff reported to him that consultation taught them how to recognize mental health issues in families. They developed deeper understanding of the relationship of families' vulnerabilities to their resistant and defensive behaviors. Staff became more sensitive to the nature of their helping relationships and how to ally themselves with families in making changes in their lives. They learned how to remain open when families brought up disturbing or anxiety-provoking topics.

Hirshberg found that not everyone on the staff was able to incorporate mental health practices. Infant mental health specialists employed by the agency particularly

benefited from the consultation and they eventually gained enough skill and confidence to become the in-house consultants. They were able to add infant mental health treatment as a service of the agency. In evaluating the success of consultation, Hirshberg reported that consultation that occurred only monthly, and without follow-up on cases, may not have been enough to support some staff to change their practices. He speculated that consultation from an outside source needed to be supplemented by more frequent in-house peer case reviews.

Maryland

Steele (1998) described the transformation of the Montgomery County, Maryland Early Intervention agency with infant mental health practices. Beginning in 1992, in aligning the agency with the new EI services mandated by the passage of PL 99-457, the agency transformed its traditional child-focused work into a family-centered focus over a five-year period. Staff were initially provided with intensive inservice training and were restructured into teams composed of all disciplines (i.e., speech-language, occupational, physical therapists, and an educational specialist and service coordinator). Teams were encouraged to use a transdisciplinary model in which only one person worked with the family and the other members of the team acted as consultants from their discipline. Teams met regularly to discuss family need and how to meet them.

Mental health consultation was provided to teams by a local mental health agency specializing in infants and young children and their families. Consultation included training on strategies for working with families, providing evaluations of family

functioning; and work with teams on their own emotional issues that arose in their work. In addition, the consultant had a designated number of hours per week to work directly with families through parent education and counseling. Staff were trained in recognizing when to refer families for mental health services.

Over time, teams became more proficient in working with families, and mental health consultation shifted to supporting the team instead of training. As staff became trained in infant mental health, the program was able to integrate infant mental health into the delivery of EI services through “an infant mental health approach providing home-based intervention, holistically addressing social/emotional/behavioral, developmental, sensory, and regulatory issues in the child and their effect on her or his family” (Steele, 1998, p. 78).

Illinois

In Illinois, EI services are undergoing reorganization on a statewide basis to incorporate the social-emotional needs of parents and children (Gilkerson & Kopel, 2005). A statewide parent and provider survey conducted by university partners had found that families in the EI system did not feel emotionally supported by services, and needed help with behavior problems; in addition, over 70% of staff felt they were not trained to support families’ social-emotional needs, particularly at the intake level. EI and other services in the early childhood system identified training and consultation with professionals with mental health and infancy expertise as needs.

Through recommendations of a state advisory subcommittee, changes were designed and tested in a pilot project that was reported by Gilkerson and Kopel (2005). As part of changing EI services, the state added a new eligibility category of social-emotional disorders (e.g., attachment disorders). Social-emotional screening was also added for all children at intake.

The Illinois pilot project was designed to build a relationship-based approach into the EI agencies, with a focus on building the quality of relationships and collaboration at the agency level as well as at the service delivery level. The project was guided by a planning committee composed of the managers, consultants, and staff at each agency as well as state leaders in social-emotional health and state-level EI agency personnel. A national consultant on relationship-based early intervention guided the planning committee and agencies in building a respectful and supportive change process. Intensive training in social-emotional development and relationship-based work was provided. Each agency received a social-emotional consultant with clinical expertise in early intervention and/or infant mental health. These new consultants were funded at the state level so that they were able to consult across cases (i.e., they were not limited to consulting on a fee-for-service basis focused on individual children or families with a mental health diagnosis). The social-emotional consultant provided weekly reflective consultation to each agency manager, and trained agency leadership in how to provide reflective supervision to staff; these two individuals planned and monitored the pilot project at their site. The manager introduced monthly reflective supervision to the service coordinators to foster empathy and support in their work with parents. The intake process

was redesigned by adding the social-emotional screening to facilitate talking about social-emotional concerns with families at the first contact with the agency. The consultant conducted regular case consultations with service coordinators and service providers. In addition, state grants were provided to develop parent-to-parent support.

At the evaluation of the Illinois pilot study, Gilkerson and Kopel (2005) reported that all elements of the plan had been implemented and active for at least eight months. Managers reported that reflective consultation was highly beneficial, and they were better able to handle staff conflict and support staff strengths. Reflective supervision by managers of staff was reviewed a moderately helpful (the majority of staff had not received supervision as part of their job previously). Support for case consultation rose over the pilot year among service coordinators, but was thought as only moderately successful by managers because not all service coordinators were able to benefit. Service coordinators thought that adding social-emotional screening at intake was very beneficial. Identification of children with social-emotional problems doubled. Interestingly, only 8% of children were eligible for EI services solely under the new social-emotional disorders category. (Most children who were identified with social-emotional concerns also qualified under other developmental areas, and children who were identified with social-emotional disorders were not all eligible for EI.) Gains self-reported by staff in skills of screening and assessing social-emotional development and in supporting and working with families were sufficient to convince the state to fund these changes in the whole EI system. It was observed that agency managers supported the changes in the system because they were included in the collaborative planning process rather than it being

driven solely by a state agency decision. New agencies were incorporated into the statewide changes in phases over three years. Initiation into the system changes continued to be a collaborative process, with control given to agencies to decide when they would receive training.

Gilkerson and Kopel (2005) observed that the elements that contributed to the success of systems change in Illinois included a) educating key policymakers; b) generating consensus through a statewide survey of providers and families about their unmet needs; c) using a collaborative system in which agencies planned and implemented changes; d) supporting social-emotional development through collaboration between mental health and disability; e) having an expert in relationship-based processes as a permanent part of the EI system.

Conclusion

Many issues have been identified in the field of EI/ECSE and early childhood mental health regarding practices that support the social-emotional development of children and the mental health of their families. These issues can be divided into three major themes: The capacity of the EI/ECSE system for identifying and supporting the mental health needs of their clientele, the accessibility and capacity of the mental health system for serving young children and families, and the capacity of the two systems to collaborate to provide optimum services. These themes will be examined in the complexity of the local contexts of Oregon services. The study design will be presented in Chapter III.

CHAPTER III

METHOD OF STUDY

Introduction

This study uses methods of qualitative inquiry to undertake an initial investigation of the practices and perspectives among EI/ECSE agencies in Oregon related to the mental health needs of their clients. Its purpose falls within applied research, which seeks to contribute to the understanding of and find solutions to social problems (Patton, 2002). The study is designed to be exploratory, using an open-ended means of inquiry to discover the practices and needs of EI/ECSE from the perspectives of personnel in the EI/ECSE and mental health service systems (Patton, 2002). It will focus only on the perspectives of service providers and administrators in order to explore the broad area of service provision of mental health in EI/ECSE.

The purpose of this study is to explore and describe how personnel in early intervention/early childhood special education (EI/ECSE) agencies in Oregon perceive the mental health needs of the children and families they serve, how they attempt to meet these needs through internal supports and through referral to the mental health system, and what recommendations they make for changes in how children and families who have mental health needs are served.

The study is composed of two parts. The first part is designed to gather broad information about the issues from programs across the state of Oregon. Breadth is intended in both the geographic and informational sense. EI/ECSE and mental health personnel in five of the nine regions in Oregon serving children with disabilities and their families were interviewed. The interview questions touched on all six of the research questions.

The second part of the study consisted of one in-depth case study of an EI/ECSE agency in Oregon that has employed a mental health consultant. Interviews were conducted with personnel in a variety of roles in the EI/ECSE agency and local mental health system. The two parts of the study will be described separately below.

Part 1: Interviews from Across the State of Oregon

The purpose of gathering information from across the state is to describe the general incidence of mental health needs in children and families being served by EI/ECSE agencies in Oregon, and to understand how these needs are being met locally through practices in EI/ECSE agencies and mental health services. Recommendations and perspectives on problem solving system weaknesses were also gathered.

Programs in Oregon have adapted to local community needs and resources, and these vary from place to place (Patton, 2002). Using a qualitative method to collect this information from sites across Oregon was necessary in order to document the diversity of programs' responses to local circumstances. Program variations occurred, for example, in training and roles of staff, strategies for working with children's behavior, community

resources, and collaboration with other agencies to solve problems around mental health. Qualitative methods were used to collect information on the diversity in program needs and practices (Patton, 2002; Reinharz, 1992). Interview methods allowed discussion between the researcher and interviewee, and opportunity for clarification (Reinharz, 1992).

Participants

Recruitment of EI/ECSE providers. A total of 28 interviews from a cross-section of disciplines were conducted by the researcher. The study was originally designed to collect information from each of the nine EI/ECSE regions in Oregon. However, the recruitment design was modified after the initial interviews were conducted.

The first interview was conducted in August, 2007 with a regional contractor to pilot-test the questionnaire for EI/ECSE providers. After approval by the dissertation committee in November, 2007, recruitment for the study began by contacting the supervisor for EI/ECSE regional programs at the Oregon Department of Education, who provided the names of the regional contractors for the remaining eight EI/ECSE regions. The first three regional contractors were contacted by email and invited to participate in the study in December 2007. One regional contractor agreed to participate, and two others referred the researcher to coordinators of EI/ECSE agencies in their regions, recommending them as informants who had more direct knowledge of agency operations and interest in mental health. These coordinators were contacted and invited to

participate. All participants received an invitation, the interview questions and the consent form by email prior to the interview.

EI/ECSE regions in Oregon are composed of between one and seven counties, and the first participants recruited for the study worked in regions composed of multiple counties. During the ensuing interviews, participants were asked to provide information on all of the counties in their region. The researcher was informed by all three participants that they were confident in providing detailed information about the mental health needs and strategies only in the counties in which they were located.

A decision was made to recruit as many of the EI/ECSE agencies in each region as possible in order to maximize the heterogeneity of the sample and at the same time to recruit information from a logical framework of agencies within regions (Patton, 2002). To keep the study within a reasonable time frame and size, however, the number of regions in the study needed to be limited. One more region was added to the study to make a total of five out of the nine EI/ECSE regions. The last region was chosen because it contained the site of the in-depth study.

EI/ECSE agency personnel were identified either by asking regional contractors for the names and email addresses of all the EI/ECSE agencies in their region, or by consulting the EI/ECSE service areas webpage of the Oregon Department of Education (Oregon Department of Education, EI/ECSE Map, 2008). All of the EI/ECSE agencies in the five regions were contacted by email and invited to participate. In three regions, all of the EI/ECSE agencies agreed to participate. However, in two of the regions, one out of the three agencies in each region did not respond.

In a sense, the recruitment of these five particular regions could be interpreted as arbitrary. However, the regions chosen incorporated 17 of the 36 counties in Oregon and a wide variety of urbanized and rural areas. This scope and heterogeneity of the study will be discussed in the section on characteristics of participants.

Recruitment of mental health providers. Each of the EI/ECSE agencies that participated in an interview was asked to identify the local public mental health agency in their county or counties. Mental health providers were contacted by email or by phone and the study was explained to them. All of the mental health providers who were invited to participate agreed to an interview. They were sent the interview questions and consent forms prior to the interview.

An interview was conducted with the majority, but not all mental health agencies that served the EI/ECSE providers in this study. In two cases, mental health providers were recruited by EI/ECSE providers to participate in their own interview. Other mental health interviewees were chosen for recruitment after EI/ECSE providers in their counties expressed serious concerns about their mental health needs being met. Six interviews were conducted on this premise to obtain the perspectives of service capacity from the mental health providers. Two additional interviews were conducted to confirm positive relationships reported by EI/ECSE. These interviews appeared to reach saturation after only a few interviews with responses closely paralleling what was reported by EI/ECSE.

Characteristics of participants. Fifteen EI/ECSE agencies in five regions participated in the state-wide study, representing services in 17 of the 36 counties in

Oregon and 1 Indian reservation. Three of the agencies served multiple counties, and the remainder served one county or Indian reservation. Eighteen interviews were conducted with 18 EI/ECSE providers. EI/ECSE participants were in most instances coordinators or program managers of EI/ECSE agencies. In addition, two behavioral specialists who worked for EI/ECSE agencies were interviewed and three participants held other positions in their EI/ECSE. One interview was conducted in August 2007, and the remainder were conducted from December 2007 through May 2008.

Ten interviews were conducted with nine community mental health agencies, representing 10 of the 17 counties. At least one mental health provider was interviewed in each of the five regions. Participants were for the most part child and family program supervisors or managers, or directors of agencies. In addition, interviews were conducted with two federally-funded System of Care program grant directors and two mental health consultants who worked for community mental health providers. Interviews with mental health agency personnel took place from January through May 2008. Participant characteristics for EI/ECSE and mental health are summarized in Table 1 below.

Characteristics of agencies and reporting identity. In order to maintain confidentiality for interviewees, agency names are replaced by generic terms, such as “mental health agency” in place of the names for local public mental health providers, and “EI/ECSE agency” or “provider” to replace specific early intervention/early childhood special education agency names.

TABLE 1. Types and numbers of providers interviewed for the state-wide study.

EI/ECSE agency personnel participating in interviews	Number of providers (N = 18)	Mental health agency personnel participating in interviews	Number of providers (N = 10)
Program manager, supervisor or coordinator	11	Program manager, supervisor or director	6
Assistant special education director	1	System of Care grant manager	2
Behavior specialist	2	Mental health consultant	2
Eligibility specialist	2		
EI/ECSE specialist	2		
Total personnel interviewed	18		10

Code numbers were assigned to each participant. To identify speakers of quotes in the write-up, the code appears as the first number, followed by a comma, and then the page number of the transcript (e.g., 012, 2 indicates the participant's code number and the page number of the interview).

In order to further protect the confidentiality of participants, the following identifying factors have been used to make broad distinctions between the EI/ECSE agencies in the participating regions in Oregon to make comparisons between them. The first distinction is between urban and rural areas. Two definitions used in Oregon for rural areas were used. First, the Oregon legislature has defined rural areas by driving distance from population centers (73rd Oregon Legislative Assembly, 2005). Rural is defined as an area at least 25 miles from a major population center of 30,000 or more in a county with fewer than 75,000 residents. Counties with very low density populations of less than 6 people per square mile are identified as frontier counties. These definitions are

used in this study to align with issues related to the difficulty of serving families over long distances. Second, the Oregon Office of Rural Health (Oregon Office of Rural Health, 2008) provides definitions of urban population centers ranging from urbanized areas to urban clusters according to population density. Rural areas are categorized as having less than 2,500 residents. These definitions were used in the study because all of the EI/ECSE agencies are located in the highest populated area of their counties. Using these two definitions, the rural and urban characteristics of the counties in the study are provided in Table 2. As can be seen in the table, 11 out of the 17 counties served by EI/ECSE agencies are rural by legislative definition. However, one of these counties has a large population center over 50,000, and four have population centers between 10,000 and 49,999.

The second indicator used to categorize EI/ECSE agencies is the relative size of the agency. Agencies in the study are categorized below in Table 3 with an arbitrary title to distinguish their sizes. Numbers of children served by each agency are listed by number of agencies and not by counties, since some agencies serve more than one county. The terminology of very large, large, medium, and small will be used to distinguish agencies in the text. There are approximately the same number of small, medium and large agencies represented in the study.

TABLE 2. Rural/urban characteristics of counties and Indian reservation (N = 18).

Urban/rural categories of counties from Oregon Office of Rural Health		Rural counties by legislative definition	
	Counties or Indian reservation in each category	Counties with driving distance from population centers over 25 miles, with total population less than 75,000 ^a	Frontier counties
Urbanized area (population greater than 50,000)	5	1	
Urban cluster (population between 10,000 and 49,999)	6	4	
Urban cluster (population between 2,500 and 9,999)	4	4	2
Rural (population centers less than 2,500)	3	2	2
Total counties and Indian reservation	18	11	4

^a *Oregon Blue Book: County Populations 1970-2006*. Retrieved May 5, 2008 from bluebook.state.or.us/local/populations.pop06.htm

TABLE 3. Number of children served by EI/ECSE agencies in the state-wide study.

Category	Number of children served	Number of agencies
Very large	Over 1,000	1
Large	400-700	5
Medium	100-300	5
Small	10-50	4

Measures

A questionnaire was designed for participants employed by EI/ECSE agencies in order to gather information on beliefs about mental health needs and practices being employed to meet those needs. This questionnaire is shown in Table 4 below.

A second questionnaire was designed for mental health service providers as a support to gathering information about the mental health system and how it was serving EI/ECSE agencies. This protocol is shown in Table 5 below.

Brief demographic information was collected from participants to document the types of disciplines being interviewed, and the extent of their experience. The interviews were designed to contain both semi-structured and open-ended questions. During the course of interviews, the questions were used as an opening for a conversation about mental health needs and services. Rarely were the questions asked in the order on the questionnaire. Instead, questionnaires were used as a guide to cover the topics being investigated. For example, interviews of EI/ECSE participants often started with the first open-ended question about the issue of mental health in their work. If the response was focused on the quality of mental health services, the researcher would follow up with a request to describe the mental health resources in more detail (i.e., Question 12). Many of the questionnaire topics were covered without asking direct questions, but through guiding participants to expand on their answers about related issues.

TABLE 4. Interview for EI/ECSE state-wide personnel.

	ID Number _____
Identifying information	
<ul style="list-style-type: none"> - Name of agency and counties served by agency - Position, length of time employed in agency, previous experience - Number of children served by agency 	
1. Could you tell me what you think about mental health as an issue in your work with children with disabilities and their families?	
2. How do you define mental health problems?	
3. Does your agency employ anyone with a social work or mental health background? If so, what do they do?	
4. Could you tell me what happens when you are concerned that a child or family has social-emotional issues or mental health issues that may be interfering with the child's development?	
5. Could you describe a general or "typical" situation in which you might be concerned about the social-emotional development or mental health of a child?	
6. How do staff react to these problems?	
7. Could you describe a general or "typical" situation in which you think a family may be experiencing mental health issues that affect their child's social emotional development or your ability to work with them?	
8. How do staff react to these problems?	
9. How many children in your agency are served under social-emotional delay or the emotional disturbance category as the primary disability?	
10. What proportion of children served by your agency need some kind of mental health services?	
11. What proportion of parents/caregivers served by your agency need some kind of mental health services?	
12. Could you describe the mental health resources for young children and families that are available in your community? Please include both public and private.	

TABLE 4. (continued).

13. How are mental health services delivered? Please think about the following questions when answering:

- Are services focused on medication management or psychotherapy?
- Are parents and young children seen together as a family?
- Are parents and children expected to see the therapist at their office, or do therapists make home visits or observe in the classroom?

14. Based on your experience, what would you say are the strengths of the mental health resources that are available?

15. What are the weaknesses?

16. In what ways does your agency provide support to staff who work with children with social-emotional or behavioral challenges? Please think about the following questions when answering:

- Is support available for the birth to five age range?
- Is this kind of support available in every program in your county?

17. What would you say are the strengths of your agency in meeting these needs?

18. What about weaknesses?

19. In what ways does your agency provide support for staff to work with families who are experiencing mental health issues?

20. What would you say are the strengths of your agency in meeting these needs?

21. What about weaknesses?

22. If you had the power to change things, what would you recommend?

23. How do you think you could get some of these changes made?

24. Are you aware of any agencies in your region that have employed a mental health consultant? If so, do you know what the purpose of the consultation is?

TABLE 5. Interview for mental health personnel who serve EI/ECSE families.

	ID Number _____
--	-----------------

Identifying info

- Name of agency
- Position and length of time employed by agency

1. Could you give me an overview of the mental health/behavioral health system in this area in terms of services for young children (birth to 5) and their families? Please include both public and private mental health services.

2. What proportion of the children/families served by your agency are referred by the local EI/ECSE agency?

3. How do you see your relationship with the local EI/ECSE agency?

4. Could you describe a general or “typical” case involving a young child referred from the EI/ECSE system? Please think about the following when you reply:

- reason for referral
- kinds of treatment or consultation provided
- length of services
- outcomes

5. What would you say are the strengths of your agency in meeting the needs of young children and families?

6. What about weaknesses?

7. Is it possible for you to consult with EI/ECSE service providers about families or children you both serve?

8. What kinds of collaborative work in the community has your agency participated in to improve services for young children (with or without disabilities)?

9. If you had the power to change things, what would you recommend?

- in the mental health system
- in your own agency

10. How do you think you could get some of these changes made?

11. Are you aware of any EI/ECSE agencies in your region that have employed a mental health consultant? If so do you know what the purpose of the consultation is?

EI/ECSE interviews. In some cases, both the interviewees and the researcher had strong agendas that took a large portion of the interview in their own direction. When participants initiated this, it was honored as an important way to learn about the unique focus of agencies and the influence of strong agency leaders on agencies' philosophies and working strategies. Some of the more deeply explored topics were controlled by the researcher, and some by the participants. For example, two participants discussed the history of collaborative relationships between mental health, EI/ECSE, and other early childhood agencies in their county. The researcher dominated the conversation in several interviews to gather unique information from agencies that made extensive use of behavior specialists.

One question was removed from the questionnaire during the course of interviews, and one question was added. The question that was dropped from the interview was the last question about knowledge of the use of mental health consultants in the region (i.e., Question 24). Since an attempt was made to invite all of the agencies in each region to participate, they could respond to this issue through a related question asking whether their agency employed anyone with a mental health background (Question 3).

During several early interviews, participants brought up a new issue related to how services were supported by collaboration among mental health and other child-serving agencies in the community. This topic was added to subsequent interviews as a new Question 24, "Please tell me how you collaborate with other child-serving agencies

in the community.” The importance of the topic was supported by the fact that a large number of participants brought it up spontaneously.

The interviews were conducted on the telephone and audiotaped by the researcher. Most interviews lasted 60 minutes. The primary reason for conducting the state-wide interviews by telephone was to save researcher resources and time. Communicating by phone also supported a high rate of response and detail (McMillan, 2004).

Mental health interviews. The interviews with mental health providers, also conducted by telephone, lasted an average of 30 minutes according to the preference of participants. The first two conversations with mental health providers occurred in interviews in which the EI/ECSE participant invited a key mental health provider to attend. The participants were prepared to talk about the issues around mental health as a team, and were encouraged to address the questions that were most compelling to them. The questionnaire was followed more closely with mental health consultants who worked directly with EI/ECSE clients. In March 2008, the first solicited interview of a program manager of a community mental health center was conducted. During this interview, the questions that focused on EI/ECSE clients appeared to be largely irrelevant because the mental health provider seemed to consider EI/ECSE an almost insignificant part of the agency’s clientele.

In January through April 2008, background reading was done on recent state initiatives affecting the mental health system. In response to this knowledge gathered from interviews and reading, the questions for mental health providers were rewritten in

early May 2008. This interview form focused more on services the agency provided in early childhood, but asked a few pointed questions about contact with the EI/ECSE system. Five interviews (i.e., half of the mental health interviews) were completed with the new questionnaire. This questionnaire appears below as Table 6.

Part 2: In-Depth Case Study

One EI/ECSE agency was chosen to participate in an in-depth case study. The agency was identified as the only one within the five-region state-wide study that was currently employing a mental health consultant through its own funding from the Oregon Department of Education. Agencies must juggle their discretionary resources or acquire outside funding through grants or fundraising in order to pay for mental health consultation or therapy. The hiring of a mental health consultant by an EI/ECSE agency is an indication of an agency's commitment to providing mental health services for its clients, and this agency was chosen because it was unique in this regard.

Participants

Recruitment. The agency chosen for the case study was known to the researcher as a participant from 2003-2005 on a federal grant awarded to the Early Intervention Program, University of Oregon. The grant studied the effects of placing a grant-funded mental health consultant in the agency for one and a half years. The researcher acted as a research assistant on the project, but had no direct contact with the agency during the grant period.

TABLE 6. Questions used with mental health providers beginning May 2008.

	ID Number _____
--	-----------------

Identifying info

- Name of agency
- Position and length of time employed by agency

1. Could you give me a brief overview of the mental health/behavioral health services in your area in terms of services for young children (birth to 5) and their families?
2. Who do you get your referrals from for young children under 5?
3. Does the local EI/ECSE agency refer families for services to your agency?
4. What changes have you made in wraparound services for young children?
5. When you are providing services for a child under 5, how do you collaborate with their other early childhood services? (such as preschool, physician)
6. What kinds of preventative services or services for at-risk children does your agency do?
7. Does your agency provide mental health consultation for early childhood agencies?
8. What kinds of collaborative work in the community has your agency participated in to improve services for young children?
9. Do you have any interactions at the administrative level with EI/ECSE (for example, do you attend any community meetings in common, or do you coordinate clients in common)?
10. What would you say are the strengths of your agency in meeting the needs of young children and families?
11. What do you see as the barriers to serving very young children and families?
12. If you had the power to change mental health services for young children, what would you recommend?

Recruitment of the agency for the in-depth case study was begun by obtaining permission from the agency's program supervisor by email. The supervisor was invited to

participate in the case study, and, in turn, invited the mental health consultant who worked with the agency to participate in the study. These two participants were asked to recommend personnel who were knowledgeable about mental health practices in their agency, which initiated a process of chain sampling (Patton, 2002). As subjects were identified, they were asked to identify other knowledgeable people, including mental health service providers in the community. Prospective participants were invited by email and sent information about the study and a consent form.

The intention of recruitment was to collect a cross-section of perspectives from different disciplines that served the same population of children and families (McMillan, 2004). It was important to include both administrators and front-line providers. EI/ECSE and mental health administrators were able to describe the official understanding of the problem and practices, and are the interface with policy makers. Direct service staff had different perceptions of the problems as they worked directly with children, families, and other child-serving agencies with which they collaborated (Argyris, 1982). This breadth of disciplines provided a number of perspectives on the issue being investigated. The rationale for including specific service roles is summarized in Table 7.

Characteristics of agency and participants. The agency chosen for the case study is a medium-sized agency located in an urbanized area in a large county that is predominantly rural. Five EI/ECSE providers and two mental health providers participated in the study. Multiple interviews over time were conducted with the supervisor and mental health consultant. Other participants were interviewed once.

TABLE 7. Participant roles in the in-depth study.

Role	Reason for inclusion in the study
Supervisor	To describe the philosophical perspective of the agency, the history of the agency's interest in mental health, information on community collaboration, and information about how mental health consultation is funded
Agency mental health consultant	To describe the mental health needs of clients and how mental health services are provided in the community
Home visitor or classroom supervisor	To provide a perspective of a direct service provider who works with families and children with mental health needs
Eligibility specialist	To provide information about how children are qualified for services in the social-emotional domain and any changes being made in the eligibility process to accommodate children with mental health needs
Community mental health provider	To provide information on how community mental health services are functioning, the availability of early childhood and family specialists, and the kinds of children and families who are served by community agencies

An initial interview was conducted in July, 2007 with the agency supervisor to introduce the study and obtain permission for participation. To gather information for the in-depth portion of the study, a total of seven interviews were subsequently conducted with the EI/ECSE agency over the course of seven months, from November 2007 through

May 2008. In addition, an interview with the supervisor of the child and family program at the county mental health agency serving the EI/ECSE agency was conducted in May 2008. The roles and number of interviews of each participant are provided in Table 8 below.

TABLE 8. Types and numbers of providers interviewed for the in-depth study.

EI/ECSE agency	Number of interviews
Agency supervisor	4
Mental health consultant	3
EI/ECSE classroom supervisor	1
Eligibility specialist	1
EI/ECSE specialist/ eligibility specialist	1
Mental health agency	
Supervisor	1
Total	11

Measures

Data collection began with a general set of interview questions that were used flexibly (Brantlinger et al., 2005). A set of questions were developed prior to beginning research, which broadly covered the area of inquiry. These can be found in Table 9 below. In subsequent interviews with the supervisor and mental health consultant, these questions were narrowed to specific topics. For example, the supervisor raised the issue of funding the mental health consultant in the initial interview. This topic was returned to many times in subsequent interviews from various angles, such as state credentialing, use of Medicaid funding, and the ability of her agency to support a consultant from general

TABLE 9. Initial interview questions for the in-depth case study.

What are the demographic characteristics of the participant, including education, experience, role in the agency, and length of time employed by the agency?

How do EI/ECSE personnel describe mental health concerns?

Why has the agency committed extraordinary resources to hiring a mental health consultant?

What are the roles of the mental health consultant?

What elements of mental health practices has the agency incorporated in its work?

What kinds of training in mental health issues and practices are necessary to support staff?

What are the boundaries of practice between mental health and education?

What changes are needed in the mental health and early intervention systems to support incorporation of early childhood mental health practices?

funds. Methods were used to deepen understanding by asking questions in different ways, and often by returning to the same topic later in the same interview. Eight of the interviews were conducted at the agency site with individual participants. Each interview lasted from an hour to an hour and a half. Three visits over a five-month period from November 2007 to March 2008 were made to the site to meet and interview the variety of participants. Three interviews were conducted over the phone in May 2008.

Interview Transcription and Data Analysis

Interviews were audiotaped and transcribed as soon as possible after conversations by the researcher. This is a process preferred by the researcher because it

not only provided a record of the interview, it allowed the researcher to rehear the information collected and to begin analysis during transcription (Patton, 2002). Notes were taken during interviews in order to make sure that the interviews followed issues that were relevant to the topics being studied, and to note the researcher's insights for future issues to be pursued (Patton, 2002). Participants were emailed full transcripts for review, proofing and clarification. Only three participants made minor additions or changes to their transcripts.

Data analysis for both parts of the study began as soon as initial interviews were completed, and continued throughout the data collection period (Bogdan & Biklin, 2003; Stake, 1995). It was accomplished in a cyclical flow between current data collection, the analysis of themes in past interviews, and decisions about who would make good informants as the study progressed (Miles & Huberman, 1994).

In data analysis, the meaning and structure of interviews and interactions with participants were analyzed by first identifying their components, and then, gradually, the relationship between components (Psathas, 1973). In the initial stages of the study, notes were marked in the margins of the transcripts to identify themes. At first, these themes generally followed the major issues in the research questions, such as how participants described the issue of mental health, strategies employed by agencies, and the capacity of the mental health system.

In the second stage of data analysis, categorical coding (Bogdan & Biklen, 2003; Miles & Huberman, 1994) was used to analyze and interpret the data. Summaries were made of recommendations, definitions of mental health, strategies, and perspectives

about mental health services from EI/ECSE and mental health providers in the same counties, and were then grouped and compared between interviews in graph or table formats (Miles & Huberman, 1994; Patton, 2002). Similar and dissimilar data were grouped for analyzing.

In the third stage of analysis, comprehensive memos were written at least monthly. Memo writing was used to document the progress of insights about the issues being raised by participants and the contextual elements that were observed (Bogdan & Biklen, 2003). Writing aided in thinking about findings within themes, and was used to summarize overall findings. Memos were shared with members of the dissertation committee.

Isolating and grouping data in this way pulled it from the context in which participants functioned. There was a continual need to return to the original transcripts to renew understanding of the data in the context of the conversations (Patton, 2002). It was possible to do this in the study because of the small number of interviews.

Sharing Results with Participants

One of the original purposes of the study was to share findings with participants. However, anonymity was sought by the majority of participants, making it difficult to share results without jeopardizing confidentiality. A summary will be compiled after the completion of the study and permission will be obtained from each participant to share their information with other agencies. To protect confidentiality in this research study, material from individual participants that was used in more substantial form was shared

with participants to ascertain that their identity had been protected to their satisfaction. Permission was obtained to use the personal identity of participants in one county.

In addition to being given copies of their interviews for correction and clarification, the participants in the in-depth case study were invited to review and suggest revisions for the write-up of their case study. Permission was obtained from all of the in-depth study participants to share their interview insights with each other.

Trustworthiness

One of the greatest threats to the validity of qualitative studies by inexperienced researchers is the potential for the researcher to misinterpret the data through inappropriate assumptions (Patton, 2002; Schutz, 1967). To ensure that the study results accurately reflected participants' perceptions and were not unduly influenced by researcher bias, several strategies suggested in the literature were used (Bogdan & Biklen, 2003; Lincoln & Guba, 1985). These included clarifying researcher biases, triangulation, member checks, and returning frequently to the original transcripts.

Clarifying Researcher Biases

Examining my own interest in the subject of infant mental health and other forms of therapy for young children and families revealed probable biases in interpreting the data. The literature search for the study relied almost exclusively on research about the influences of family dynamics on the early development of children with and without disabilities. Literature from infant mental health theorists and practitioners, and EI/ECSE

professionals who were invested in bringing a mental health focus into EI/ECSE services were the predominant literature sources. This interest was operating in the choice of the agency for the in-depth study. However, using an emergent form of data gathering in the state-wide study was well-suited to denying this bias undue influence. Encouraging participants to pursue issues of their own choosing largely prevented the researcher from steering data collection toward personal interests. In order to maintain awareness of personal biases, reactions and assumptions were recorded in the form of memos throughout data collection and analysis.

The interest in infant mental health and relationship-based work served well in the portions of interviews that focused on relationships between and among agencies. As explained earlier, this issue was spontaneously brought up by many participants and was added to the questionnaire during the study. Through personal interest, conversations about the supporting relationships provided to staff within agencies, and the relationships between EI/ECSE, mental health, and other agencies were encouraged to deepen.

Triangulation

In a study such as this in which one method of data collection was used, credibility was improved by incorporating diversity in the types of respondents chosen (Lincoln & Guba, 1985; Patton, 2002). In the state-wide study, diversity was achieved by choosing participants from as many of the EI/ECSE agencies as possible in five regions in Oregon, as well as interviewing both EI/ECSE and mental health providers. It was particularly important to have participants from the mental health system in order to

compare what individuals said who were operating in different systems. Their inclusion was intended to support understanding of the complexity of issues surrounding mental health services. In the in-depth case study, data was collected from several subjects, some of whom were administrators and some of whom were direct service workers (Bogdan & Biklen, 2003). Improving the credibility of the data this way is commonly called triangulation, though Bogdan and Biklen (2003) caution against using the term because of its impreciseness.

The design for data collection in the case studies could be criticized because the researcher did not spend a prolonged period with respondents (Lincoln & Guba, 1985). Although only three site visits were made for the case study, they took place over a five-month period to allow the researcher to gain the interest and trust of participants, and to follow up on issues in more depth. Over the course of time, it became possible to document the changes in role experienced by the mental health consultant.

Member Checks and Returning to the Original Transcripts

Another method to improve credibility to the findings is by incorporating challenges to the researcher's interpretation process (Lincoln & Guba, 1985; Patton, 2002). In this study, the dissertation committee members were consulted when a major decision needed to be made about changes in sampling and to bounce off major findings (Bogdan & Biklin, 2007; Patton, 2002; Stake, 2000).

Member checking of the data analysis by participants is another way of getting more than one perspective on interpretation (Lincoln & Guba, 1985) and of increasing

the validity of the study. As was mentioned earlier, participants in the in-depth study were provided with a draft of the final write-up on their agency to provide their suggestions and corrections.

However, the main source of challenge to researcher bias was to return over and over to the original interviews. Doing this grounded the researcher's impressions in the context of the information, and many adjustments were made in interpreting the data in the process of returning to the original interviews. This greatly increased the ability of the researcher to remain critical of her own assumptions (Psathas, 1973) and set aside preconceptions about the data.

Protection of Human Subjects

Approval from the University of Oregon Office of the Protection of Human Subjects was obtained for the regional and in-depth parts of the study. Ethical considerations required that respondents be informed in advance on several levels about their participation. The first level was the nature of the study. The researcher informed potential respondents that they were participating in a dissertation study that had as its aim the collection of information about a social problem, and sought their perspectives and recommendations. The researcher could not promise that their participation or her work would get them any closer to the solution of the problem, nor that the study would benefit them (Stake, 1995). They were informed that the study may be published in some form in the future. The second level on which participants must be informed is the burden of time that they would need to commit to participate, and the types of participation. The

researcher informed them of the approximate time commitment for participating in interviews, reading transcripts or summaries of conversations, and participating in member checks of the researcher's final draft of data analysis. The third, and perhaps most important level, is to provide informed consent. In this study, information was collected that pertained to participants' perspectives about a problem faced by their agency. It was not focused on gathering private information about their personal lives.

Personal Influences and Ethical Considerations

The study is motivated by feminist ethics in its relationship with participants. This is a core motivation, but not the overt focus of the study. Its feminist ethics are expressed in the relationship to participants (Thompson, 1992). The choice of interviewing as the primary mode of data collection is consistent with an interest in avoiding control over participants and developing a sense of connectedness with peers (Reinharz, 1992). It is expressed through conducting research and sharing findings in a way that is cooperative and empowering to participants. Examples of sharing findings during the course of conducting interviews included passing on information about grant or conference opportunities obtained from previous participants and sharing research findings. Many participants expressed interest at the end of their interviews in hearing what strategies were being used in other agencies in the state. In a general way, information about what had been discovered was shared while still maintaining confidentiality of sources.

There were several occasions in which statements made by participants were personal in nature, and did not appear to have a bearing on the study. These were

purposefully omitted. In some cases, opinions were omitted in which participants identified particular individuals with whom they worked that were of an unfavorable and criticizing nature. Participants sometimes requested this deletion when they did not want to make public their opinions of people in their communities with whom they had working relationships.

CHAPTER IV
STATE-WIDE STUDY: EI/ECSE PARTICIPANTS' DEFINITIONS OF AND
STRATEGIES FOR WORKING WITH MENTAL HEALTH PROBLEMS

Organization of Results

This investigation was organized around six research questions:

1. How do EI/ECSE agencies describe the mental health needs in children and families they serve?
2. How do EI/ECSE agency personnel describe the ability of their own personnel to understand and support children's social-emotional development?
3. How do EI/ECSE agency personnel describe the ability of their own personnel to understand and support the mental health needs of families they serve?
4. How do EI/ECSE agency personnel describe the ability of their community to meet the mental health needs of children and families they serve?
5. How do mental health agency personnel describe the ability of their community to meet the mental health needs of children and families served by EI/ECSE agencies?
6. What recommendations do EI/ECSE and mental health agency personnel make about improving services to support children's social-emotional development and the mental health needs of families they serve?

In the analysis of results, participants' responses to these questions will be addressed in three chapters. Chapters IV and V will present results from the state-wide

study of EI/ECSE and mental health agencies in five EI/ECSE regions in Oregon.

Chapter VI will be devoted to the in-depth study of one EI/ECSE agency.

The first of the results chapters, Chapter IV, will examine the state-wide responses to Research Questions 1, 2, and 3 related to EI/ECSE agencies' definitions of the problem, and strategies for working with children and families with mental health issues. Chapter V will compare the state-wide responses of EI/ECSE and mental health providers to Research Questions 4 and 5. Participants' recommendations, in response to Research Question 6, will be interwoven in both these chapters where appropriate, and are summarized in Chapter V. Chapter VI will present the results of the in-depth study of one EI/ECSE agency. This chapter will address all six research questions.

Introduction

The concern that many researchers have expressed about the mental health of young children with disabilities and their families has been discussed in some detail in the first two chapters of the study. Children with disabilities have been documented to experience a higher rate of mental health problems (Batshaw, 2002), and are vulnerable to maltreatment to a greater degree than typically developing children (Steinberg & Hylton, 1998). Research on parents of children with disabilities has shown a greater prevalence of depression than the general population (Singer, 2006). Maternal depression, the co-morbidity of depression with other mental illnesses, and the adverse life experiences of parents with psychological disorders have been linked to poor developmental outcomes in young children (Downey & Coyne, 1990; Seifer, 1995). Family dysfunction, including interpersonal conflict, drug and alcohol addiction, and

aggression between parents, combined with the vulnerability of children with disabilities, are particularly disruptive to children's social-emotional development and the onset of behavior problems (Kazdin, 2000). Young children's serious behavior problems, in turn, have been associated with the early origination of mental health disorders (Severson & Walker, 2002). Expertise is often needed from mental health professionals to distinguish between transitory behavior problems and serious disorders (Kazdin, 2000).

The results of this exploratory study will focus on how EI/ECSE agencies in Oregon describe and work with these problems. Questions such as how seriously EI/ECSE providers are concerned about the mental health of children and families, how they understand the role of families in children's mental health, and what strategies they use in their work with children and families will be examined in the results from data collected from 15 EI/ECSE agencies in Oregon in the state-wide study.

Describing the Mental Health Needs in Children and Families

The chapter will begin with a discussion of how EI/ECSE providers in the study described their understanding of mental health in their work with children and families. Their perspectives in this section will be organized from two directions. The first examines participants' responses to a general question about the issue of mental health in their work with families, how they measured its prevalence, and ways that children with potential mental health problems were made eligible for services. The second examines how providers defined mental health problems, and how this definition was related to the way EI/ECSE agencies provided services.

The Issue of Mental Health in EI/ECSE

Support for the importance of mental health in the field of EI/ECSE was found in the universal concern expressed by EI/ECSE providers for the mental health of their children and families. They used descriptors of the problem like “huge issue” (013, 1), “a big issue” (007, 2), and described the incidence of rising mental health problems in children and families. “Mental health has become more of an issue over the last five years than ever before in dealing with kids with delays, of the birth to five age range,” explained one provider. “Probably of any of the delays and disabilities areas that has increased, the behavioral, the character education, the mental health education is the one we talk about more and more” (014, 3).

Some EI/ECSE providers described their concerns generally in terms of family systems, with sensitivity to the greater strain on families who have a child with a disability. A coordinator with many years of experiences viewed mental health as an inseparable aspect of working with young children and their families. “I think as specialists in our program, we are trained to offer that in a variety of ways,” she said, “but we always see some type of a social-emotional component or social-emotional overlay in any family we work with” (008, 2). Others were more specific in describing the kinds of mental health problems that they encountered in families. An eligibility specialist described the wide variety of family situations he saw. “Given our mandate, we see whoever walks through the door and has a developmental delay. So we see high income families, low income families. You could have high income families with outrageously wild mental health issues. Low income families with no mental health issues. Low

income families with poverty mental health issues of their own. Chaotic environments, abuse histories, all kinds of stuff” (002, 2).

However, the majority of EI/ECSE providers associated mental health issues directly with families in poverty. A large urban county identified changing demographics and population growth in low-income areas of the county with increases in the number of children who were experiencing mental health problems. “I think it is a big issue. If you look at the demographics in the county area, there is a lot of movement out of the downtown area into other parts of the county. So the poverty rate is increasing out in that area. This results in an increased number of children living in poverty, and risk factors associated with that” (007, 2). Many providers located in rural counties also cited the poverty and isolation of rural life and the lack of resources as causes of families' distress. “I have seen moms that certainly look to be suffering from chronic depression because they are not connected,” said one provider in a frontier county. “They are home with their kids, and that’s their life. Domestic disturbance-types of things are a pretty big deal in our county and they happen quite a bit. With that poverty, a lot of families are just trying to survive. So development, education and nurturing of children sometimes just falls by the wayside in a lot of those cases” (016, 2).

Mental health issues were often associated with children and families in the child welfare system in both rural and urban areas. One large urban mental health provider summed up the problem as, “Drug and alcohol, drug and alcohol, drug and alcohol. It’s all drug and alcohol” (004, 8). EI/ECSE providers in a large agency covering multiple rural counties estimated that 25% of their children were involved in the child welfare system (024, 6), although this was the highest rate reported among EI/ECSE providers

interviewed. One of these providers stated that children with child welfare involvement in her agency fluctuated from year to year, but that EI/ECSE served a high proportion of maltreated children. “We are very rural,” she explained, “so our numbers don’t appear to be high, but for the percentage of the population, they are high” (028, 4).

The federal legislation that mandates child welfare to refer young children to EI/ECSE for developmental screening (i.e., the Child Abuse Prevention and Treatment Act or CAPTA) has strengthened the relationship between agencies. Two frontier county providers reported their close collaboration with child welfare in trying to find placements for children. They had strong working relationships with child welfare, and believed that they were more in touch with each other because of the CAPTA agreement. “We do lots of screenings in kids, even with kids that aren’t in the CAPTA age range,” said one. “So if we have a sibling that’s younger, in the CAPTA range, and then there’s a 4-year-old in the home, we do an automatic screening with that kiddo too, and we meet and talk about potential referrals” (016, 6).

Although the concern for the rising incidence of mental health problems of children in EI/ECSE programs was universal, the numbers of children who were estimated to be experiencing mental health problems to a serious degree varied greatly between agencies, from very few in three agencies (008, 010, 014) to as many as 50% in another (019). One agency set the figure at 10% (002), and three others at 20% to 30% (013, 018, 024). One provider stated that he couldn’t separate children and parents, and set the rate at 20% for families (016).

The few agencies that provided estimates of children who had behavior goals written into their IFSPs also varied greatly from about 2% to 15%. At the lower range,

two providers in a medium-sized agency described the number of kids as “a handful,” but still significant. They estimated that three or four children who were between three and five years old had behavioral goals written on their plans, and out of that one might be referred to mental health. They also identified one child under age three. “It’s pretty minimal,” they said, “but there are pretty significant needs, whether there is one or there are five or ten of them” (014, 10). In a very large urban agency, the proportion rose to 15%, including both severe and more moderate behavior problems. The provider, a grant manager for a System of Care mental health grant, explained that the state estimated the most severe cases were 5% or less, but that they consumed about 80% of the mental health budget through hospitalization and residential treatment. He estimated that his county served another 10% of children did not have severe problems, but were referred for behavioral and social-emotional services, and these services appeared on their IFSPs (04, 4).

Very few children were served under the categorical label of emotional disturbance (ED), or under social-emotional delay as the primary eligibility. The largest number of children served with the ED eligibility reported was three, and it occurred among children served in the largest agency in the study (007). The EI/ECSE and mental health providers serving this agency discussed the issues related to mental health diagnoses of severe emotional disturbance (SED) for young children, and explained that in their program, children with severe mental health issues were most likely to be qualified as developmentally delayed in domains such as social-emotional and adaptive rather than being given the label of ED. They believed that mental health providers were very cautious in diagnosing children with SED as early as age three, and that it would be

used only after they had gathered information through working with the family. “Within the mental health system,” a mental health provider explained, “it is really difficult to get an Axis I diagnosis for the little ones. DSM-IV doesn’t even go down below age 4, and we really try to avoid heavy-duty labels. We often deal with adjustment disorder NOS. It is used as the diagnosis so we can have the least labeling possible for a 2-year-old” (003 & 004, 4).

Several providers discussed ways they could make children eligible who had primarily social-emotional difficulties without using the ED label. Agencies used their own behavior specialists or school district behavior specialists as part of the eligibility team when they suspected behavioral or mental health problems. Agencies could also refer the child for an evaluation from mental health (014, 11). An eligibility specialist in one large agency stated that he always worked within the guidelines of the Oregon Administrative Rules for eligibility standards in EI/ECSE, but that there was a fair amount of flexibility built into the categories. He believed that it was not uncommon to find a child whose screening showed he was developing typically in all areas, but his social-emotional development was still being affected because of mental health issues, or lack of support at home. These children could be made eligible for EI/ECSE services if the agency could prove that mental health issues were affecting their participation in an educational setting. During the evaluation, the eligibility team conducted observations, behavior checklists, and interviews with a variety of caregivers in order to put together a case that the child’s developing mental health issues were negatively impacting their ability to participate in a typical educational setting like a preschool or a daycare (002, 3).

Many providers discussed the reasons for rarely using the ED label. Often emotional delays were associated with other related problems such as communication and adaptive concerns, and providers felt more comfortable making them eligible under those delays. As one provider explained, “If we can bring it in under another one that is just as valid, we feel much more competent at making that determination” (014, 11). Other providers cited the difficulty of documenting emotional disturbance in young children and they typically brought a child into services under developmental delay in adaptive and social areas, and then did more behavioral observation and testing once the child was in services (005,4).

An experienced EI/ECSE provider who had been working for many years in the field predicted that the use of the ED label would increase as staff in EI/ECSE became more trained in the mental health needs of children. “You know, it is hard to put that label on kids,” she said. “I think it will change as people understand more about the needs of preschoolers with really severe emotional issues, because it is also an education issue for our staff....I think if we are going to honestly look at kids and their needs, we need to be able to identify them with, I hate to use the word “label,” but that’s my bias. And I think as we see, hopefully, more and more focus on preschool kids with mental health issues, it couldn’t help but impact what we do, similarly to how autism has impacted us as the numbers have risen significantly over the years” (020, 3).

Summary. EI/ECSE providers have serious concerns about the mental health of the children and families they serve. Figure 1 summarizes how providers responded when asked about mental health as an issue in their work. Most participants discussed how children’s social-emotional development was in jeopardy. They described mental health

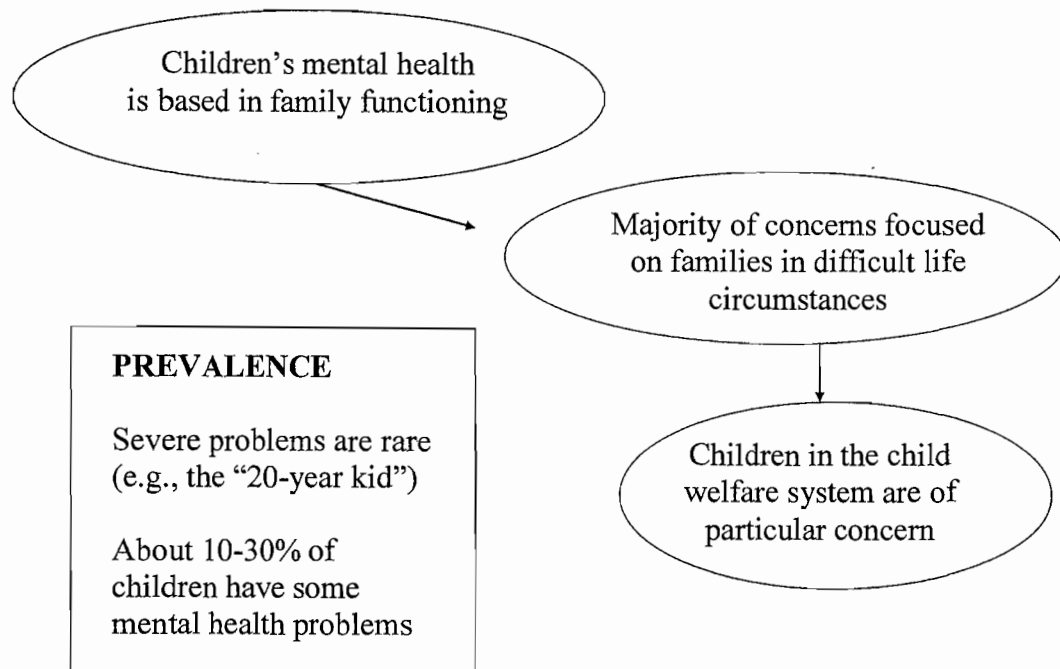


FIGURE 1. How EI/ECSE providers described the issue of mental health in children and families.

and social-emotional development of children holistically, as part of family functioning, and they identified threats to social-emotional development among the large proportion of families they served in poverty, particularly families that were involved in the child welfare system. Yet when questioned more closely about the numbers of children with serious mental health problems, they reported that at the young age they serve, they did not see a large number of children who had developed severe problems. Prevalence of severe problems was rare, but the 10-30% of children who had some mental health problems were still considered a significant issue by providers.

Providers' discussions about how children with social-emotional problems were made eligible for services is a reflection of how intermingled all of the developmental domains are in children's early development. Very young children often have not developed serious enough delays in social-emotional development to qualify for special education services under that domain alone. However, related domains of communication and adaptive, or self-care, are the ones that are initially affected by poor family relationships, lack of stimulating home life, and neglect. As discussed by the provider above, children were most commonly made eligible through the social domain combined with either communication or adaptive when early developing mental health problems were suspected.

In the next section, conversations with providers about how they defined mental health problems identified a focus of concerns among many agencies on older children who have developed aggressive patterns of behavior.

Definitions of Mental Health Problems

The most frequent definition of mental health problems in this study was related to behavior problems of children in classroom settings. When asked about mental health concerns, most agencies talked about serious aggressive behaviors among children in the three through five age range. For example, one eligibility specialist described how children were first identified as having social-emotional problems. He reported that the typical situation occurred when the agency received calls from parents about children with behavior issues. When the evaluation team investigated the context of the problems, they found that the children were having trouble with their relationships in preschools or

daycares. They were unusually aggressive with other children, and were in danger of being kicked out of child care. Concerned parents were referred to EI/ECSE by preschools and daycare providers or by family doctors to take a look at the behavior issues (002, 9).

Some providers explained the focus on the three to five age range as the time that children come to the attention of the community. One provider speculated that when children exhibit serious aggressive behavior problems in child care, it is the first time outside of the home where there are concerns brought to the public (014, 10). Many providers identified children with aggressive, disruptive behaviors as the primary focus of their intervention. This trend of identifying primarily acting-out children was a cause of concern for some providers because they realized children with withdrawn behaviors were not as likely to receive attention. This concern was reflected in comments from two providers when they described the typical referrals they received from the community. “When it comes to this area,” they said, “the first call is about kids that are getting kicked out [of preschool]..... It is usually the aggressiveness. You’re not seeing too many of those calls about kids who are withdrawn.... I would say that’s an area we haven’t been as strong in, is the withdrawn child. It’s easier to deal with the acting out child” (003 & 004, 6).

A related definition commonly used was that children with serious mental health problems, or those who needed to be referred to mental health services, were children whose behavior exceeded the traditional behavior management repertoires of ECSE teachers. As one coordinator explained, “EI/ECSE teachers’ training is in the educational realm. Instruction related to the domains of cognition, adaptive, gross motor, fine motor”

(007, 6). Their expertise extended to putting behavioral strategies into place and providing a structured environment in the classroom to focus children's learning. However, if the child's behavior could not be managed by these strategies, there was a need for mental health services. "When you are working with kids and you just have this sense that the structure is there," she said, "the positive reinforcement is there, the infrastructure is there, but you know you are walking on eggshells and you just have a band-aid on it...those are the ones you are going to say, we need a little bit of expertise here" (007, 6).

More extreme mental health problems in preschool-age children already served by EI/ECSE agencies were in some cases related to an attempt to distinguish between characteristics of disability and mental health problems. It can be pointed out that this kind of difficulty in defining mental health problems often reflected EI/ECSE providers' discomfort with their lack of mental health experience and support. One medium-sized rural agency described difficulty in distinguishing whether they were seeing early mental illness (013, 2). The coordinator for this agency stated she did not have adequate mental health support from her county agency, so that she sought other resources to decipher the causes of children's behavior. In other agencies in which mental health partnership was available, the need for an opinion from mental health providers in this kind of situation was confirmed. Two mental health consultants who worked with EI/ECSE agencies appeared to believe that EI/ECSE providers needed training in recognizing mental health problems. In referring to her work with teachers, one mental health consultant commented, "Sometimes they tended to see it in terms of the disability. Sometimes it is the disability, you know, like sometimes you might have a child with autism who also has

an anxiety disorder, and so I think it is easier for them because of their training to think of it more of a characteristic of autism, rather than the fact that it could be an overlay on top of that. And sometimes it is both” (012, 4).

Discussion of issues. Figure 2 provides a summary of how EI/ECSE providers defined children’s mental health problems in this study. The focus on children ages three to five brings up several interesting issues. Identification of mental health problems as existing in children in this age range may be partly explained by the proportion of EI and ECSE children served. The agencies interviewed served an average of about one-third of their children in EI (i.e., age birth to three) compared to two-thirds in ECSE (i.e., age three to five). In frontier counties the proportion of EI kids was even smaller, in some cases only 25%. Yet, this is not likely the best explanation.

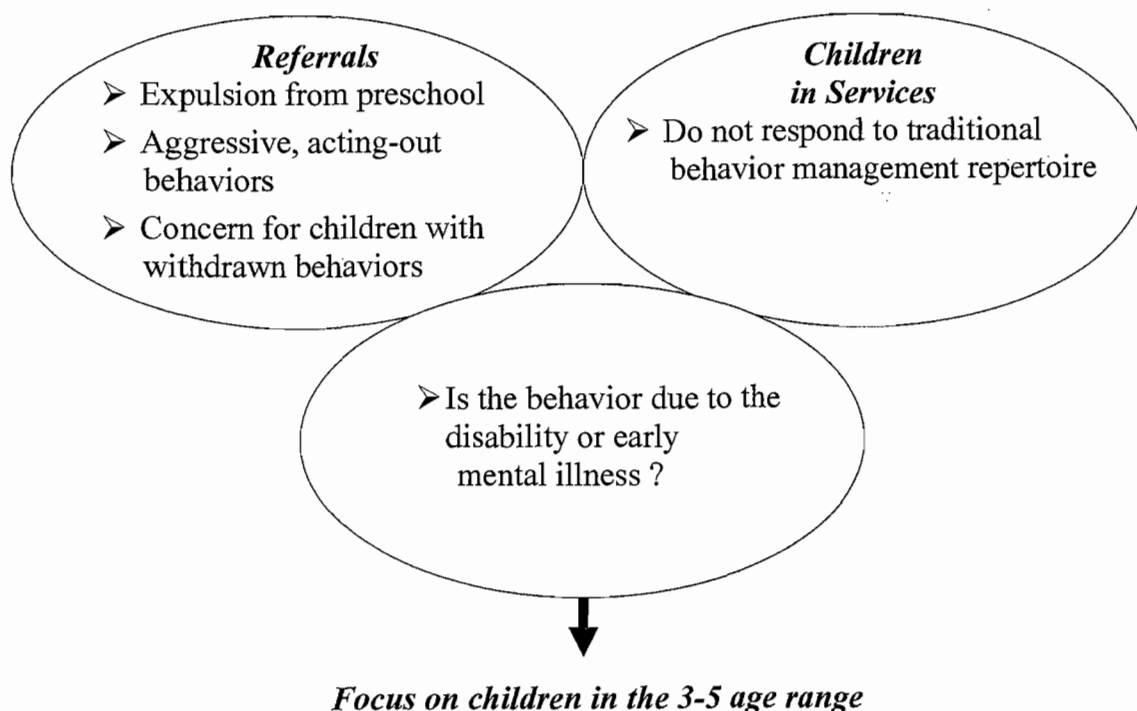


FIGURE 2. The ways EI/ECSE providers defined mental health problems.

In this study, the use of behavior or mental health support among staff serving children under three and their families was mentioned in only a few cases. One EI/ECSE coordinator in an agency with behavior specialists described the need for support among EI staff serving children birth to three, but mentioned that they didn't seek it from behavior specialists as often as classroom teachers. She believed that EI specialists working in the home could recognize early social-emotional problems, and knew when they needed to refer children for behavior services. However, she realized that she did not receive many requests from EI home visitors for behavior support (007, 6-7).

Another provider stated that her agency didn't have enough behavior specialist time to currently provide support for her home visitors. In a funding shortage, she used her budget to support behavior specialists for older children. "We don't currently have the funds to provide as much support as we possibly could just for [home visitors with] kids with the attachment issues and things like that," she explained. "We are not currently staffed to provide for those kiddos. So that would be a weakness, I would say, for our programs across all our counties" (005, 3). This is not to say that EI/ECSE agency coordinators were not concerned about the mental health of children younger than three who were served through home visiting. Yet, references to this service group were usually only in passing in the majority of interviews, and did not receive the amount of attention that behavior management in classrooms did.

It is probable that in the state-wide study, the focus on older children's behavior was related to the research design. A lack of focus on working with families on home visits among most of the state-wide interviews may have emerged from the open-ended way that the interview questions were asked, and through the fact that participants were

allowed to choose the issues they wished to talk about. In the limited time allotted for interviews, there was often not enough time to deeply explore issues that were not brought up spontaneously by participants. However, the fact that the majority of participants chose to associate mental health problems with children in classroom settings is still a significant finding, and another explanation for it will be explored below.

Among the 15 agencies that participated in the study, providers in only three agencies said that their agencies focused their primary concern in the birth to three age range. One of these participants had an explanation for why most EI/ECSE agencies focus on older children's mental health problems. She identified the cause in the different federal laws that originally created the birth to three and three to five services. Federal legislation has been an influence on how services are now designed for each age group, and, she explained, the resources expended on them are not equal. "If you look at how the public law is written," she said, "there is not really free appropriate public education (FAPE) mandated for birth to three-year-olds in EI. There is more protection and higher expectations for services for three- to-five-year-olds." She believed the emphasis on three-to-five-year olds was a system issue in how services were budgeted. In her agency, she identified home visitation as a less expensive service to provide than preschool classrooms. "Even two-day preschools sort of funnel the dollars away, and the expectation is that you spend more because of FAPE," she explained. "The law doesn't protect birth to three, and in a resource-deficient world, you put the money where your requirements are" (011, 4).

One of the agencies that discussed concerns about the birth to three age range had integrated support for its entire range of services. This agency had developed good parent

support services, including regular parent support groups run by behavior specialists. More will appear on this agency in the section entitled, “A Richer Contextual View of How EI/ECSE Agencies Function.” The other two agencies that had a particular interest in services for children birth to three philosophically aligned themselves with the need to intervene with families as early as possible in order to influence children’s early brain development. They were well educated in the effects of trauma on young children’s brain development in the population of low-income families they served. One of these providers believed that EI/ECSE was lacking in relationship-based or infant mental health-related services that support attachment in the first and second year. In looking at it from a funding viewpoint, she argued, working with the parent-child relationship from the very beginning would defray costs for expensive mental health problems that would develop later (011, 3).

In her opinion, where most resources have been put in EI/ECSE are in direct contradiction to where they are most needed. “If you look at it from a brain-growth standpoint,” she said, “the point in time your brain is most malleable is in the first three years. This is when you can shift a kid’s cognitive scores up 10 points or so, depending on which study you read, and yet that’s the point where we provide the least amount of services” (011, 3-4).

As has been shown in the discussion of participants’ responses to questions about the general issue of mental health in their work, they nearly always associated it with families who were experiencing life difficulties that made it hard for them to support their children. In contrast, however, the majority of the participants defined mental health problems in terms of preschool-age children whose behavior could not be managed by

the traditional intervention strategies they could provide. This interesting difference brings up the mental health dilemma faced by agencies that serve young children. The EI/ECSE providers in this study recognized that young children's well-being is always fundamentally supported or undermined by their families. They understood that children would not make significant gains unless the whole family received intervention. However, EI/ECSE providers rarely have social work or mental health training that allows them to work with families' mental health issues. EI/ECSE providers work in an educational setting focused on children's skill development and appeared to see themselves as limited in terms of what kinds of support they could provide caregivers.

Most of the EI/ECSE providers in this study, at least those working in classroom settings, appear to see themselves as only able to control the educational setting. As will be shown in the following section, they confidently described many and varied working strategies that supported children's learning, even when children's mental health problems were severe. The place where many EI/ECSE providers repeatedly identified a need for mental health partnership was in working with caregivers who had mental health needs. These over-riding issues and others will be found in more detail as the responses of EI/ECSE providers about their strategies for working with mental health problems are explored below.

The Ability of EI/ECSE Agencies to Support Children's Social-Emotional Development and the Mental Health Needs of Families

As has been previously discussed, interviews with EI/ECSE agencies focused primarily on the strategies they have developed to work with children with behavioral and mental health problems, and not on working with families. For this reason, strategies

for working with children will be focused on more heavily in this section. Since many of the definitions of mental health problems were related to children in the three- to-five-year-old age range, most of the energy of EI/ECSE providers in this study appear to be focused on developing strategies for children in classroom settings.

All of the agencies in the study have developed expertise in behavior management in their teaching staff. Although one very large agency has a long-term partnership with its county mental health for mental health consultation, and a few other large agencies have behavior specialists, the majority of the agencies in the study do not appear to have the resources to dedicate employees solely to behavior management. Instead they have developed the expertise of several of their staff through training and experience. This section will begin by reporting on strategies used by these agencies that rely on general personnel to work with children with mental health and behavioral problems.

Expertise in Behavior Management Among EI/ECSE Staff

Many providers identified the skill level in their staff as highly competent in working with behavior problems. Agencies had long-term staff who had developed experience over years of working with children with behavior and mental health challenges. A typical description of skill in this area was provided by a coordinator in a large agency. She identified a leadership team of employees who had worked in the agency for 10-15 years. They were capable of doing functional behavior assessments, and making behavior plans in the classrooms. “We have enough sage sorts of souls here that can go in and devise some behavior support-type of plans within classroom settings,” she reported, “so that is not where I think we have our big need” (011, 3).

The skills of EI/ECSE specialists were praised highly by a behavior specialist in a large urban agency, who said, “It’s rare that people don’t already get what you do to support kids, and make sure that you are reinforcing the behaviors you want to see instead of scolding over behaviors that you don’t want to see” (021, 1). Her agency coordinator also described the highly skilled ECSE teachers who ran behavior classrooms for children who had large social-emotional needs, but were otherwise mostly typically developing. The classrooms provided opportunities for “work on social skills, and social-communication in very small group settings.” As children improved their social skills, they transitioned to community preschools with support from ECSE consultants (020, 4).

One classroom teacher was interviewed who was highly skilled with children who had mental health disorders. As an ECSE teacher in a large education service district located in a rural area, she had been teaching children with severe mental health problems for eight years, in a county in which the mental health services were overburdened. “I’ve actually had, in the last four years, three kids on my caseload who have been diagnosed with severe emotional disturbance before the age of five. On average I’ll have at least two kids on my caseload with ADHD. This year alone, I have five. I have one child on my caseload who has a diagnosis of oppositional defiance along with ADHD” (028, 2). Yet, this teacher described the behaviors in her classroom as “minimal,” even in a large classroom of 22 children. She attributed this to the consistency in staffing she was able to maintain, and to her team’s positive behavior support (PBS) strategies. “We practice PBS in the classroom, where we try to set the environment to promote positive behaviors. Instead of necessarily being reactive to behaviors, we are being proactive before they start. So there are clear expectations of what is needed to happen in the classroom. At the

beginning of the year we establish four basic rules, and the rules are always worked on throughout the whole year. If I catch somebody doing those rules, I make a big deal about the fact that they are doing them. “Wow I really like how Johnny is using his walking feet!’ ” (028, 2).

She provided a consistent environment and response from teachers so that children had a predictable environment. “Even the kids who are severely emotionally disturbed know what is expected of them here. I have an extremely high tolerance for things that would normally bother other people, that don’t necessarily bother me or my team, because there are some things they just cannot control....They need opportunities to be able to work through and talk through things” (028, 3).

This was a dedicated teacher who chose to work with this population of children. She was able to maintain a consistent team of instructional assistants who were highly trained and disciplined. She sometimes brought children into her 3 and 4-year-old class as early as age 2 ½ to give them a safe environment. “That’s not always the best practice to do, but when we have environmental issues with the families, when child protective services is involved, I tend to bring some of those kids in earlier to be able to have a safe environment and start talking about rules and expectations so they have some structure and consistency” (028, 4).

This teacher stated that it was difficult in her agency to maintain well functioning classrooms because of the high turnover rate of instructional assistants. Providers in this education service district believed that staff needed a great deal more training to work with families and to improve their understanding of social-emotional development in children with disabilities. Many of the teachers were in need of more training in working

with kids with severe mental health problems. Teachers who were interviewed recommended that the EI/ECSE agency add a social worker or family service worker who could focus on family needs and connect them with community resources.

In another medium-sized agency in a rural county, the coordinator praised the quality of support her agency could give children. She contrasted the success of children in her program with what happened when they transitioned to elementary school. She explained that in EI/ECSE agencies, families received support from a whole team of people, often beginning in the home. She observed that children with emotional problems who had been successful in her integrated preschool classroom often did poorly when they transitioned to a larger school setting. “Things start to unravel for kids with significant behavioral or emotional issues. You have kindergartens with 20 kids and one teacher. It’s a big change from a preschool class where you’ve got 12 and maybe 3 staff to be facilitating social skills. You know, the kindergartens are becoming more academically focused anyway, so that social-emotional aspect isn’t being supported as it has been in years past” (008, 4).

Support for management of children’s behavior extended to working with parents in the home when services were routinely provided there. In a frontier county where many of the families in remote parts of the county received their services through home visiting, the EI/ECSE provider concentrated on supporting parent skill development. “What I try to do from an educational standpoint,” he said, “is create successes within the family with the kids, as far as increasing parenting skills. So that is focusing around having better behavior, trying to get a better, more manageable schedule, kind of trying to change their environment” (016, 3). In working with parents who were isolated and

sometimes suffering from chronic depression, he focused on helping them see their children's progress. "If that is their life and that is what they are feeling, let's do the best we can do in making it productive and enjoyable and happy for the parents, for the Moms in most cases" (016, 3). This provider thought there was a strong need for a social worker or family counselor in his education service district. This would be someone he could refer families to for mental health treatment or help solving problems of daily living.

Another EI/ECSE provider in a very small agency, when asked if the lack of mental health services in her county caused her problems, replied that her early childhood agencies experienced fewer extreme mental health problems than others she had heard of around the state. Although she worked closely with the community mental health agency when needed, her skills in working with challenging behaviors took care of most of the behavior problems. She reported having only one or two children with significant behavior problems at any one time, and didn't necessarily view their problems as related to mental health. She described working with one child who responded to the structured environment in her classroom. "As the year moved on, he got into a structured routine, and he improved measurably. So his family didn't need mental health services" (010, 3). She admitted that figuring out how to respond to children's behavior could be very time consuming. "Everybody wants quick fixes for their kids," she observed, "they want quick fixes in the classroom. And a lot of this is labor intensive. You have to figure out what the kid is trying to tell you, and look at your environment, and then look at changes that can be made. Experiment with a few things, and then debrief those changes that you've made, and experiment, and then go from there" (010, 3 & 12). This provider desired a partnership with a mental health therapist who could come into her classrooms once a

week to work with all the children on social and behavioral issues. She believed that teachers in her Head Start and ECSE classrooms needed training on environmental interventions such as keeping distractions to a minimum in classrooms, having teachers use calming behaviors and speak in low voices, and employ visual schedules and maintain routines.

In contrast, another medium-sized agency in a rural county reported mental health problems in a large number of its children. It employed a long-term EI specialist who was particularly interested in mental health and had educated herself through conferences and classes. The agency hired a part-time mental health therapist who had an L.C.S.W. degree to partner with her in offering social skills groups for children. The two staff provided play therapy for children who were pulled from the classroom for multiple week sessions. This agency coordinator stated that she desired much more access to private counseling for her children. Her entire staff was interested in mental health training, but she had been unable to find adequate training (013).

As has been shown in examples from many EI/ECSE agencies, experienced staff were available to work with children with behavioral and mental health problems. Yet when asked about how services for children could be improved, agencies desired more training, more support for families, and mental health services for children integrated into their agencies. In a few regions in the study, programs were able to offer more integrated services by hiring behavior specialists. A discussion of how these specialists were used occurs in the next section.

Programs with Behavior Specialists

An EI/ECSE supervisor summarized the philosophy of many agencies for working with children with mental health problems. “I think for kids that have mental health concerns, our primary service that we provide for our children is behavior services. These support kids in their educational settings” (005, 3). Her agency’s “behavior services” were provided by behavior specialists in addition to skilled teachers. Her statement is an additional example of how the expertise that has been developed by agencies in this study mostly focused on children with mental health problems who were in classrooms, in other words, children who were three to five years old. In speaking for her agency, she said that the focus was on behavior management of children, implying that it was not on helping parents improve their relationships with their children, or what infant mental health calls relationship-based work.

Two regions in this study employed behavior specialists. One will be described in this section, and one will be featured in the section entitled “A Richer Contextual View of How EI/ECSE Agencies Function.” A large multi-county education service district employed four behavior specialists specifically dedicated to the EI/ECSE agencies serving the region. At least one of the behavior specialists had a social work degree, and another had a special education master’s degree and a great deal of experience working with children who had severe emotional disturbance. The behavior specialists who were interviewed for this study were careful to explain that while they may have held mental health degrees, they did not provide mental health treatment. Their role was to support agency work with difficult behavioral and mental health problems through behavior management.

All of the behavior specialists that served the EI/ECSE agencies in the region were part-time employees, and often also worked with school-age children. One of the behavior specialists, who had a very small FTE, trained and certified the staff in a non-violent crisis intervention called the Mandt System (Mandt System, 2008), a de-escalation program used when children and adults have difficulty managing their own behavior. Three additional behavior specialists were assigned to classrooms and worked with teachers, children, and families. They provided a range of services including consulting with classroom teachers and carrying a caseload of children who had behavior support goals on their IFSP (007, 7). One of the behavior specialists worked extensively supporting staff in learning to use positive behavior support (PBS). She described the basic tenets of PBS as having a relationship-based focus. “It involves making sure kids’ basic needs are met,” she explained, “that they feel safe, that they feel like they belong, that they are recognized, making sure that those things are really in place, and people value that” (021, 2). She consulted with teachers in understanding children’s behavior specifically as communication and in setting up social skills groups. “Sometimes kids are only trying to communicate,” she explained, “that’s all they’re trying to do, but they don’t have the words, they don’t have the social skills, and they resort to some of the things we don’t like to see, like biting and hitting and kicking. So I help teachers recognize that what they are trying to do is communicate, and help them give children a different skill for getting that need met. Children require instruction, including social skills instruction, including rules” (021, 2). She said that her consultation with teachers took a variety of forms, from sitting together and problem solving, to formally conducting a functional behavior assessment and behavior plan.

Behavior specialists in this region also participated in informal and formal evaluations of children who had mental health concerns. This could occur when the child first entered services, or through an IFSP meeting after the child had been in services and needed changes in support. In an agency that served two of the counties in the education service district, the EI/ECSE supervisor explained, “We make referrals to mental health when we see mental health concerns, and also access our behavior specialists. All of our classrooms have access to the behavior specialist. So if they have a child that is coming in, then the behavior specialist will go out and do an initial consultation with them, and if need be we will move forward with a formal evaluation” (005, 4). One of the behavior specialists for this region reported that she participated in eligibility meetings for two specific disability categories, which were Other Health Impaired and Emotional Disturbance (ED). Decisions for Other Health Impaired eligibility involved children who were being assessed for ADHD diagnoses that may appear in young children (021, 3). This behavior specialist had rarely encountered children who were made eligible for the ED category, but described a recent case in which she participated. The child, whose current eligibility was through developmental delay, had made good progress with behavior support and a very skilled teacher in a specialized behavior classroom. His eligibility was changed to ED when he was ready to transition to kindergarten so that he would receive the specialized supports that he needed there (021, 3).

In addition to the two regions that directly employed behavior specialists in their EI/ECSE agencies, other regions had behavior specialists available through their regional services programs. Regional services programs provided specialists throughout the region for children with high needs. However, in three of the small agencies located in isolated

frontier counties, the coordinator rarely or never called on the regional behavior specialist because the regional center was located in an adjacent county and long distances were needed to travel to their agencies. One coordinator explained that regional behavioral specialists wouldn't serve his kids unless they were fully eligible for regional services, which were only children with severe disabilities. "And even then, they don't like to come over. Because we are 2 ½, almost 3 hours from where the regional program is. I have heard they have a behavior specialist, but I imagine they are kept pretty busy in their local area. Coming over the mountains in the winter really adds to people's dislike of travel" (016, 10). The EI/ECSE coordinator in another isolated county explained her reason for never calling a behavior specialist by saying, "If they were here, we would. See, over here in the rural area, you do what you have to do to make it work, because you don't have any other resources" (010, 5).

EI/ECSE agencies were creative in meeting their needs for behavior support, however. Most developed relationships with their local school districts for behavior support when they could not afford to hire their own behavior specialists. A medium-sized agency in a rural county benefited from an agency agreement to use behavior specialists employed by a school where his ECSE classroom was co-located. "We have a system in place where they are easily accessible through the districts. Even though we don't employ them, we have a mechanism to have access to a few more of the resources" (014, 10). The coordinator described an event that showed the close personal collaboration between their programs. "One of our teachers was out ill," he said, "and the support staff in that classroom, who knew the behavioral specialist who happened to have an office down the hallway, went to get her and brought her down because of a child

coming off the bus cursing and kicking and all that kind of stuff. Our classroom staff, especially at a time when they are not fully staffed, really needs all the support” (014, 10). When asked for their recommendations for improving services for children and families with mental health needs, this agency expressed a need for someone who could provide recommendations for working with challenging behaviors who was internally available to his agency.

In one of the frontier counties, the EI/ECSE coordinator described how school psychology services were available, but only if the family lived near the school. “We had some good ideas from our school psychologist earlier this year, in developing some token systems, rewards and consistency for one child who was in preschool here. And that was a change through our school psychologists here to put together a good plan, at least for this family” (016, 4). This cooperative relationship was only available because the family lived in the largest town in the county, where most of the services were located. He admitted that “the geographic challenge is a big thing and a barrier that is not going to go away” (016, 4).

In some counties, EI/ECSE agencies that had employed behavior specialists had lost them because of budget cuts. One large agency had previously employed up to six part-time behavior specialists and a social worker, but could no longer afford them because of budget constraints and rising caseloads. In another large agency, the EI/ECSE currently employed two school psychologists, but because the agency was experiencing a high number of evaluations, did not use them as behavior specialists. This region was suffering from a rapid growth in caseloads that was severely taxing their resources. “As far as counseling for the families, or providing parenting classes, and things like that, we

just don't have the staff to do it," explained one of the eligibility specialists. "Right now, honestly, we are just surviving getting the education pieces in. We don't have enough people nor funds to even cover our EI/ECSE components" (024, 3).

As has been mentioned, behavior specialists assisted in referring families for mental health treatment, but they did not provide mental health treatment in EI/ECSE agencies. Mental health consultation is the next step up from behavior specialists in combining mental health expertise with the ability to provide some brief therapy to families and children, and a service that was desired by many agencies in the study.

Programs with Mental Health Consultation

Only one EI/ECSE program in the state-wide study worked intimately with early childhood mental health consultants that were funded by the county. The program had been in existence since the early 1990s. The Multnomah County Early Childhood Mental Health (ECMH) program was originally founded to provide mental health services in Head Start programs (American Psychiatric Foundation, 2001). It currently served Head Start, Early Head Start, Migrant Head Start, Oregon pre-Kindergarten, EI/ECSE programs and the local child care resource and referral agency (American Psychological Association, 2001). The program had been available to EI/ECSE, according to Nancy Anderson, Associate Director of Special Education for Multnomah Early Childhood Programs, "...for probably over 10 years, so it's been fairly stable and pretty good funding for the county for that number of years. I mean every once in awhile we have to go to bat to try to maintain those positions. But it has been pretty well liked by the whole area" (003, 2).

Currently about 14 consultants were out-stationed or “hosted” in early childhood programs. Three consultants with a total of 2.8 FTE worked in the EI/ECSE programs of Multnomah Education Service District (MESD) (012, 3). The consultants were employees of the Department of County Human Services, Mental Health and Addiction Services Division. MESD contributed approximately 10% of the consultants’ salaries and provided office space and supplies (012, 3-14-08). One of the consultants explained that the consultation time was accounted for by filing weekly reports on the details of their work, such as how many classrooms they visited, teachers they consulted with, and children they saw. The weekly accounting of the mental health consultants was tabulated and used to generate figures for the county commission to monitor whether they were meeting their goals (012, 3-14-08).

The mental health consultants were part of a continuum of EI/ECSE services for children with mental health issues, including a social worker in part of the county, and a cooperative day treatment funded by both MESD and the Albertina Kerr Center. Two therapeutic classrooms had been established for children ages three to five in which the EI/ECSE provided teachers and the mental health center provided outpatient therapists and psychiatrists (007). Therapists followed children through the first year of kindergarten to make sure services were in place. The program began its work with children younger than three who were showing unusual behaviors through consulting with home visiting staff. The program was funded by several sources, including Kerr funds, Oregon Health Plan, and the City of Portland Children’s Investment Fund (003, 2).

Referral to services with the Wraparound Oregon System of Care grant project could be made for children with more severe, complex needs and involvement in multiple

agencies. The Wraparound Oregon Project Director, Rob Abrams, felt that the county had a strong support system for young children with mental health problems. He described the collaboration between special education and mental health as “fairly robust and strong and healthy” (004, 5). He believed the education of all early childhood partners was such that “if a family presents with a child with significant or any kind of mental health issues, somebody is going to pick that up and work with that....There is always this case management piece that says, we need to provide linkages, we need to have numbers that we can call, and we need to make those referrals and follow through” (004, 5).

The coordinator of the EI/ECSE program described how the mental health consultants became integrated into work with EI/ECSE staff in their first years. She reported that the mental health consultants were seen as somewhat separate from the program until they began to provide support for staff in the classrooms, and as consultation with teachers evolved, the consultants also added a parent training component by presenting the Incredible Years training once or twice a year for families. “Over the years,” the coordinator explained, “they have really been feeling more and more like part of the program....As practices have changed, the mental health consultants are also more on board with the philosophy of early intervention. Even though they are the mental health workers, they still have to align themselves with our philosophy. I think there has been more collaboration and change in that way for the better” (007, 8).

The ECMH program consultants had their offices in the two main sites of the EI/ECSE program, where they worked directly with staff. The consultants for the various early childhood programs attended a general staff meeting together at the county twice a month (012, 2). One of the clinical social workers who worked for EI/ECSE described

how the mental health consultants stationed in different early childhood programs worked together. She worked closely with consultants in Head Start programs where ECSE kids were placed. “I’m following one child there, because they have so many kids, and only one mental health consultant. Even though the consultant is based at the site, we actually work together. She provides support to the teacher there, but I work with the family more, and then we meet and, for example, when we are doing positive behavior plans and that sort of thing, we all work together” (012, 3).

The consultant had worked as an ECMH consultant in EI/ECSE for the last 10 years. She commented that a large percentage of her job was spent as a behavior specialist, working in ways similar to behavior specialists in other programs. She explained that sometimes teachers introduced them as behavior or social-emotional consultants to families who might be leery of mental health. Each consultant was assigned to specific classrooms and teachers, where they helped teachers interpret children’s behavior, “to kind of ferret out if it is mental health, or if it is something else” (012, 4-6). They worked with teachers on environmental arrangements, and on strategies for working with groups and individual children. Teachers most often used them to work with individual children in writing behavior plans for the classroom or coaching parents on parenting skills (012, 4-6).

The consultant had regular contact with all the classrooms she was assigned to by visiting each classroom regularly at intervals within a couple months to check on how each classroom was functioning. For the birth-to-three services, she relied on home visitors to contact her when they had a family they wanted her to visit. She commented that this worked when she had an established relationship with home visitors, but it was

more difficult to establish contacts with new staff when she did not have an opportunity to see all of them regularly (012).

The consultant felt that her consultation was of real benefit to the agency in the way that it exposed and educated teachers that children could have serious mental health problems like anxiety, depression and attachment issues. She believed that this had helped teachers become more sensitized and aware. The sensitivity extended to asking the consultant to work with families at home on problems that the child was only showing within the family (012, 9).

The EI/ECSE coordinator also believed that teachers had high satisfaction with the mental health services because they were able to be so versatile in where they could serve children and families. She saw some friction in the different ways that teachers and mental health consultants worked on cases. "Sometimes teachers are more action, and quick acting", she said. "They may say, 'Why does this process take so long?' The mental health process sometimes takes longer. It's not about 'do this' and then everything is going to be ok. It takes more problem solving. But I would say that overall they would be pleased with the support they have from mental health consultants" (007, 8).

Although therapy is not considered part of classic mental health consultation (Cohen & Kaufmann, 2005), the mental health consultants in this agency provided some brief therapy to children and families. In addition to their behavior specialist functions, consultants were also able to open a case for providing short-term mental health treatment. The treatment focus could be on individual play therapy for children, family therapy, or on improving parenting skills. The majority of children the interviewed consultant worked with were three and four, but consultants also saw a significant

number of babies starting at about a year old. Working with parents who had younger babies was more rare (012, 4-5).

The consultant provided an example of how she integrated therapy and behavior support. “I am doing some play therapy with a little guy who was adopted and has a lot of issues. I am working with the school as well to try and understand his particular needs based on his life experiences, to structure the education plan to meet some of those needs. We go to IFSPs, and help with behavior support” (012, 7).

Consultants were able to work directly with families as long as the therapy was related to children’s development. She reported that consultants were not supposed to work with parents on their own psychological issues. She provided an example of working with a mother who had her own issues stemming from abuse and neglect as a child. “It made sense for us to talk about some of those issues, and how her kids are different, and that sort of thing. We just call it family therapy, but we may do it without the kids there” (012, 7).

The consultant often referred families for counseling because her caseload was large. She felt that families could get adequate counseling services through community mental health as long as it is related to the relationship with their child, because most Oregon Health Plan coverage in these cases was through the child and not the parent. They attempted to find referrals for parents, but there were few services available if parents did not have private insurance. In one case, the consultant was able to refer to an Hispanic treatment therapist so that the parent could work out some of her own grief issues related to her child. “This Hispanic treatment therapist that we just referred to was

free, and that's very unusual. Sometimes it's really tough to get family therapy that they need, very, very tough" (012, 7).

The ECMH consultant described the consultants' jobs as very busy, with each of the three consultants responsible for a third of the 1500-1700 children served by the EI/ECSE agency. She traveled to sites all over the city. Sometimes she was only able to make an observation of a child in the classroom, and then make suggestions to the program coordinator instead of getting more involved. "We couldn't see all of them individually, we just couldn't," she said. "So we do a lot of referring out. If the family has their own insurance, we really try and get them to use that and get their own therapist. If they have access to Medicaid, then we try and refer to the other mental health programs that we have relationships with" (012, 7).

Mental health consultants in other programs. Two other EI/ECSE agencies in this research study had access to mental health consultants. One of these programs will be featured in the in-depth part of this study (i.e., Chapter VI). The other consultant was funded by the state Oregon Children's Plan (OCP) grant. This consultant was employed by a rural county mental health agency and worked 20 hours/month with early childhood programs. The consultant reported that the primary purpose of the grant was to serve some of the children who need mental health services and whose families did not qualify for the Oregon Health Plan. "Through my children's mental health grant, I have been about to see quite a few families without charging. I just bill it out as a consultation, and the grant covers me for that," she reported (015, 4). She had consulted with classroom teachers in the EI/ECSE program over the three years of the grant, and also served on the local interagency coordinating council and worked closely with the coordinator of the

EI/ECSE program. Much of her work involved parent coaching with families that were highly stressed over their children's behavior. "When you work with kids, a lot of it is parent coaching," she said, "helping them with behavior support strategies in the home, getting them feeling like they are back in control of the discipline. A lot of behavior problems reduce when the parent can figure out how to be in charge without being over-emotional. So I sort of coach them through that. Not in the moment, but through our talking" (015, 1-2). She often used the popular parent coaching strategy called *1-2-3 Magic* (Phelan, 2004).

The consultant was a specialist in children age birth to 8. She was not part of a formal early childhood team at the local mental health agency, in a county that had few other child providers. She mentioned that it was sometimes difficult to work as the sole mental health consultant without direction about how to help programs. She believed that she would have been more effective if early childhood programs had been better informed about how to use consultation (015, 3-17-08).

Summary of Issues

EI/ECSE agencies in the state-wide study had a wide variety of strategies for working with children and families with mental health issues. The core of agency strength lay in the skills of teachers and home visitors who developed experience in behavior management through years of working, team support, and training. In some agencies, very skilled and motivated teachers provided structured classrooms for children with mental health diagnoses or other serious mental health problems. It became clear

that the ability of EI/ECSE specialists to manage children with difficult mental health issues was competent in many agencies.

The next level of support that agencies used when they could afford to was behavior specialists. Behavioral specialists may be considered “hybrids” between general EI/ECSE staff and mental health consultants, particularly when they have mental health degrees. It is interesting to compare the roles of mental health consultants with those of behavior specialists. If we can use the role of the Portland ECMH consultants as a “gold standard” for the state, it appears in this limited study that behavior specialists who are trained in mental health perform all the tasks of a Multnomah county mental health consultant with the exception of treatment, and sometimes have other tasks, such as running children’s social skills groups. The EI/ECSE teachers and specialists who did the work of behavior management for their agencies for the most part did not have mental health training but were effective nonetheless at many of the same roles, including setting up environments, doing functional behavior analysis and behavior plans, and problem-solving all but the most severe mental health problems. The comparison of roles are summarized in Figure 3.

Some EI/ECSE providers described their methods as positive behavior support, but many teachers have worked much longer than early childhood PBS has been around. They received training in behavior management during their teacher training and on the job. The promotion of PBS in EI/ECSE agencies around the state by the Oregon Department of Education appears to be giving EI/ECSE teachers a focal point for sharpening their management skills and vocabulary for linking it to the foundations of children’s social-emotional development.

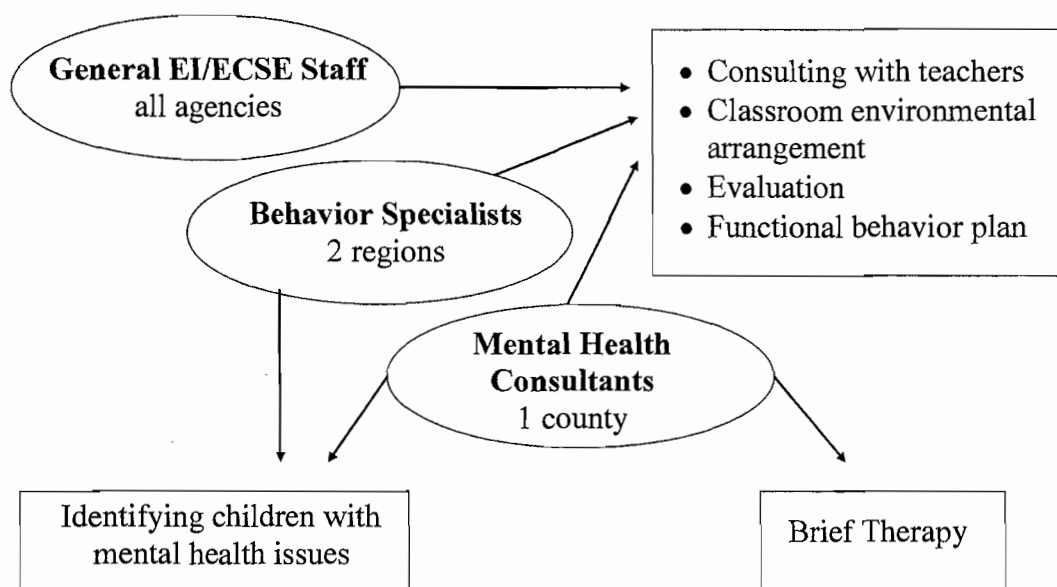


FIGURE 3. Strategies used by EI/ECSE programs for working with children and families with mental health concerns.

Clearly, the creativity in strategies is driven by the need to provide services to children with behavioral and mental health problems in whatever form that agency staff resources can be brought. Resources appear to be a driver of what kinds of staff EI/ECSE agencies are able to employ. The ability to employ behavior specialists did not appear to be linked merely to the size of an agency in this study. Several large agencies had lost behavior specialist support, while agencies that served fewer children employed them.

The Multnomah county ECMH consultant who participated in the study identified some core problems in the mental health system, even though her team of consultants was able to fill a great deal of the roles that are needed by children and families with mental health problems. She identified the lack of mental health services for parents that was apparent even in a high functioning system. In her description of the size of

caseloads for mental health consultants in EI/ECSE, she also provided a vivid indication of the extent of the need of young children and families with mental health issues.

Analyzing information and providing isolated descriptions of how EI/ECSE agencies in Oregon view and strategize about mental health problems does not provide a true sense of how agencies actually solve their problems. EI/ECSE agencies vary greatly in size and resources, and work in many different kinds of communities. In the final section below, a more holistic view of how EI/ECSE agencies in this study are functioning will be presented.

A Richer Contextual View of How EI/ECSE Agencies Function

Each of the agencies in Oregon that participated in the study, though connected to regional systems and following state standards, designed solutions a little differently. In the following section, short vignettes of four of the agencies have been written in an attempt to picture unique ways that EI/ECSE agencies address problems regarding mental health in the context of their own communities, summarized in Table 10.

Vignette 1: Interagency Collaboration to Overcome Scarcity of Resources in an Isolated Frontier County

I am it in this county. I am the Coordinator, I write all the IFSPs, I do all the assessments, other than the little pieces that the related professionals do on their own. And so I am busy providing service all the time, and it is very difficult to do anything but that. But one of the things that we do in this county, and I think we do it very, very well, is we have a lot of interagency collaboration. And we work very closely with the community mental health program.... We are all providing a lot of services, but we take the time to keep connected and talking. I think we are ahead of the game compared to some other counties in having established and maintained those relationships. (019, 1)

TABLE 10. Four vignettes: Overview of agency solutions to problems in context.

Interagency Collaboration to Overcome Scarcity of Resources in an Isolated Frontier County <ul style="list-style-type: none"> ◆ County characterized by isolation, high mental health needs, and low mental health capacity ◆ EI/ECSE agency has one employee ◆ Frequent interagency collaboration to share resources and solve problems
Education of a Whole Community in the Social-Emotional Needs of Children <ul style="list-style-type: none"> ◆ All of child-serving agencies in county participated in social-emotional training ◆ Development of working relationships and mental health capacity through continued training and collaboration
Supporting Parents with Mental Health Problems <ul style="list-style-type: none"> ◆ Agency characterized by high proportion of parents with mental health problems ◆ High FTE of skilled behavior specialists with mental health degrees support agency's mental health capacity ◆ Parent support through regular parent groups and meeting centers
A Prevention Model in the Community <ul style="list-style-type: none"> ◆ Skilled behavior management among a few staff ◆ Offer behavior management strategies to preschool partners ◆ Help community agencies identify referrals for mental health

In a large and geographically isolated rural county with few mental health resources, close interagency collaboration has helped support children with mental health problems in the EI/ECSE system. All of the child-serving agencies in the community participated in close collaboration, including the Commission on Children & Families, Child Care Resource and Referral, the county librarian, Head Start, and a non-profit that provided community parenting groups and worked with parents who were under court-ordered parenting education. The EI/ECSE coordinator participated in a much wider base of child-serving agencies than those that served the age range of her children. She

attended community resource teams, meetings for integrated intensive treatment services provided by mental health, and multidisciplinary team meetings on child abuse cases. "It is the same players that call these different meetings," she explained. "We have the early childhood group, and then we have the service integration team. That includes some of the older kids' agencies -- juvenile department and that type of thing. We are working on lots of prevention, working on immediate needs, just making that a priority to put service aside a couple of days a month and get together as a group" (019, 2).

The EI/ECSE coordinator identified the most difficult part of her job as providing mental health services to the children in her program. "Again and again, I feel like we give lip-service to the kids that really need that mental health piece," she said. "And there are just more and more of them....The sad thing is that my three- to five-year-olds are already on that track many times. They've already had experiences that are literally defining them. You want to give them all the supports they need. That feels like a struggle to me" (019, 1-3).

The coordinator identified the most extreme examples of early mental health problems as re-occurring in generations of the same families. "When it's a small place, you know who those families are, and we probably have more insight. Last year we had a child who we called a '20-year kid.' We have good experienced Head Start teachers, who have been doing this for about 20 years, who said, 'We've only had one other kid like this, and it was from the same family.' That's kind of our typical really, really hard case that we see" (019, 9).

She had developed many strategies for working with children, but needed help from other professionals when her traditional interventions failed to work. "Nine times

out of ten, you give them what you know,” she explained, “and they respond. It’s those kids that aren’t able to respond, aren’t able to get comfortable in their skin, aren’t able to learn. We’ve had kids that are violent, we’ve had kids that are not autistic but are tactilely defensive, tense and tight, and not being able to work through that. Then we look at that as a mental health referral” (019, 9).

At the time of the interview, the coordinator had just received eight referrals to screen child maltreatment cases for child welfare. She knew they all had mental health needs, but she speculated that none would enter her services because her screening system would not pick them up as eligible for special education services. “The founded abuse case kids at ages three to five,” she said, “are cognitively so far ahead. They are kids who have been cooking their own meals, solving their own problems. They don’t show up, just by the way the screening is set up socially and emotionally, they come up ahead of their peers....I can’t even get my hands on them” (019, 3). The lack of therapeutic foster homes in the county compounded the problem.

She served all of her children through consultation since she did not have a dedicated ECSE classroom; she visited them in daycares, at babysitters, at community preschools, and in Head Start. Head Start was a source of identification for children who had been isolated from the community until they entered preschool. She described her county as a place that some people came to drop out. “But,” she said, “once those kids start in Head Start, they are there everyday because it’s good daycare for families. It’s good, free, they are fed, and all of that. And you see these kids that you have never seen before who have these huge needs, kind of coming out of the woodwork” (019, 5). The coordinator valued her relationship with Head Start because it provided a small degree of

mental health support, but the lack of services in the county affected both agencies. She explained that, “You do your mental health observations, you do your referrals, but you are still stuck with relatively few professionals...they have the same people here that we do. The kids I am talking about are that 1% that are not manageable, you know. Really, really tough cases. Everybody’s got those” (019, 6).

The coordinator was not served by an EI/ECSE behavior specialist, although she would sometimes use the school psychologist at the local school district. Since she was a sub-contractor and the regional services were located two hours away behind terrain that was impassible most of the winter, the she was not able to call on a behavior specialist very often. The regional support was available, but the distances made it impractical. “Anytime that I’ve called, they are willing to give me anything they’ve got. And they are willing to send out their people. But just by geography, that makes it very difficult” (019, 13). Training in behavior management and social-emotional development was difficult to obtain because as the sole EI/ECSE provider, she was not able to leave her job often.

The coordinator worked closely with parents in helping them obtain services. For children with severe disabilities, this often meant that parents had to take their children to a specialist who was five hours away. The coordinator put a high priority on providing emotional support to parents in her isolated county. While maintaining professional standards, she was able to communicate through personal experience a sense of strong and sensitive support for parents. “I really want these families to feel good about what they are getting here,” she explained. “And I think the people I am working with feel the same way.... I can say, ‘This is what we can offer. There are ways that you can find to

make this work for you if you want to stay here, and I can help you do that.’ There is so much family support that is needed so early” (019, 8).

The community had a small mental health agency with three professionals who served children, including a psychologist who saw children in the community, a social worker who did the mental health observations for Head Start and headed the intensive treatment services for the county, with a child psychiatrist coming in once a month. Mental health, EI/ECSE, and Head Start collaborated to serve the children with the most disruptive mental health problems. She related that when they had the most desperate situation, “we have that relationship established and mental health has been able to provide, kind of gone out of the box a little. And all of us who work with young children in the county work really hard at that collaboration piece, because we just can’t do everything for every kid. All of us are in the same boat” (019, 1). The capacity wasn’t there in the community to provide mental health services to other children who needed it. The EI/ECSE coordinator believed that 50% of the children on her caseload needed more than they were able to offer (019, 10).

The coordinator understood through experience in her tight-knit community that the mental health needs of young children are “too big, and the repercussions are too large, for families, for communities” (019, 13). Her vision for better services encompassed the needs of all counties. Therapeutic foster care should be a high priority, she believed, along with therapeutic classrooms. She stated that she would like to see a mental health behavior specialist in every county, “who could just focus on kids. Be with them day to day. Somebody dynamic and trained, who could see where a child is and could immediately take them to the next level” (019, 13).

Vignette 2: Education of a Whole Community in the Social-Emotional Needs of Children

For me it is all about prevention. It really is....If we have securely attached children, a lot of the rest of those things that can go wrong don't. And if we can help everyone to understand what it takes to have a child be securely attached, then we've given them a solid foundation. (014, 13)

A medium-sized EI/ECSE agency in a rural county participated in a community-wide training to support children's healthy brain development. According to its director, the agency had until recently felt ill-equipped to deal with the increasing issues related to children's mental health using its traditional staffing. "While we're staffed with home visitors, and specialists, and preschool teachers," he explained, "for the most part, a large part of what we do is based on somewhat of an educational model. So, especially our three to five service providers don't come to us with experience and training in what to do with kids who are not mentally retarded, developmentally delayed, communication-disordered, those eligibility categories that are the gatekeepers to getting services in our program" (014, 3).

The agency and the community were in a transformational period after a group of the county agencies invested in community-wide training in a prevention approach to support the social-emotional needs of young children. They received consultation and training from Dr. Bruce Perry of the ChildTrauma Academy. All of the community agencies that worked with families supported a group of 28 people in the community to go through the training. The end result, he said, "is that we have this foundational prevention kind of knowledge base, and most of us are pretty dedicated to the idea that this is information that we want out there for every parent....The county as a whole is aware, invested, committed to the idea" (014, 3-4).

The agency had been developing its own internal resources by hiring specialists who participated in the Perry training. One was a new EI specialist with public health experience who came over to the EI/ECSE program from mental health. She was a participant in the interview.

The core group of people who were trained by Dr. Perry had become trainers in their own agencies and for other communities in the region. The EI/ECSE coordinator described how their program had continued to train staff members until the philosophy had become part of the agency's culture. This built on a philosophy held by agency personnel that they needed to be involved in community advocacy for children and families. Many had volunteered for years for the court appointed special advocates (CASA) program supporting abused and neglected children, for the mental health advisory board, the commission on Children and Families, and the Citizens Review Board that reviews foster placements. "We work within a system of people, identifying where the needs are and making a concerted effort to support that need," the coordinator explained. "Our networking is so tight in this little area that we continue to come to the table with dedicated people to get the job done....And I think you see that more in smaller communities where you've got to work with your neighbor, because you may not have all the resources that a more metropolitan area might have" (014, 8).

The county did not currently have providers who were trained in infant mental health work, but was doing long-term planning to build this into its mental health services. The new EI specialist was particularly interested in obtaining training so that she could become a mental health consultant for her agency. Problems in the community were solved collaboratively through relationships that had developed through the Perry

training. “Whether it’s a parent who needs help, or a child who needs help,” the coordinator related, “we know where to start to find answers. We may not have procedures in place, but we are at the point where we can call and say, ‘I need some help. This is what’s going on’ ” (014, 6). The agency’s goal was to integrate a mental health consultant into their agency to support staff and work with children with behavioral challenges. “I think we are meeting some of my expectations with the close bond that we have to our mental health community for children and through adulthood,” the coordinator said. “So that piece is already in place. I think this is a pivotal year for us, because our new EI specialist is being able to bring some things to us that we never had access from a staff member before. I think this is the year, and hopefully into the future, that we are going to start to build some systems that we haven’t had in place” (014, 11).

Vignette 3: Supporting Parents with Mental Health Problems

We try to do as many parent groups as possible. It’s not therapy, but it is parent support and education. They will understand what is going on with their child, and maybe make better decisions for their own lives too. (002, 12-14-07, 2)

A large EI/ECSE agency located in an education service district that served multiple counties had developed a strong emphasis on behavior and mental health support. The agency currently employed four behavior specialists, all of whom had counseling or social work mental health degrees. A behavior specialist was assigned to each community that was served by the agency, providing services for children “with more extreme social-emotional needs, something that would need a more specialized approach than, say, a teacher would provide,” according to the EI/ECSE provider (002, 7). Behavior specialists helped teachers determine how mental health issues were

contributing to children's behaviors and their inability to participate with their peers, and they also worked with parents in the home addressing children's social-emotional needs. "They'll be consulting with the families to try to get things arranged at home," explained the EI/ECSE provider, "so the child can be more successful and the parents can be happier, and feel like they are making more progress" (002, 10).

Behavior specialists provided intervention directly with children who had a wide variety of mental health issues and their families. The EI/ECSE provider described their role as almost a triage approach. "They tend to work with kids that are aggressive, or showing those early signs of mental illness, there are some of those coming around. They will work with kids who are extremely withdrawn. We've had quite a few kids with anxiety issues, different sorts of school phobias or social phobias. That's come through in waves over the years" (002, 10).

The EI/ECSE provider reported that many of the EI/ECSE teachers in this agency had become comfortable and competent working with children who had mental health problems through training and experience. "It really has gotten to the point around here," he said, "that many, many of our teachers are really sophisticated in working with kids with behavior and/or mental health issues" (002, 12). The EI/ECSE provider felt that teachers and home visitors must be comfortable working in what he termed "the blurry area" between mental health and educational issues. Parents often disclosed information about their themselves that was outside the providers' working expertise. "A lot of parents are very forward about that," he said. "They won't be shy. They want to do the best for their kid, and they'll say, 'You know, I really struggled with methamphetamine addiction when I was pregnant with this child, and I feel really guilty about that because I

am thinking the delays are due to that exposure.’ And, ‘You know, I was beaten as a child, and I had these experiences, and I struggle with depression off and on.’ Those things come up all the time” (002, 13).

EI/ECSE specialists received support in their team meetings from behavior specialists and other providers who helped them learn how to maintain their professional boundaries. With experience they were able to provide therapeutic support for parents. The EI/ECSE provider said they might ask questions such as, “Do I make a referral here? How do I support this mother? Do I have to be careful about crossing any lines here?” He described some new staff as somewhat uncomfortable, but they received support from the more experienced staff who were very comfortable talking with families and knowing where to draw the line in terms of providing mental health services. “And a lot of the families have felt really supported by the teachers over time,” he observed, “because they really value their child’s growth and development, and they see the teacher as an ally in helping them do that. And if the teacher is going to listen while the parent’s talking about the difficulties they have had, and they might still have, especially in addressing the kid’s needs, then that relationship is solid as a rock and they are really comfortable talking” (002, 13).

The agency served children whose delays may be related to the mental health problems of their parents. Children were often referred for behavior issues, typically when parents called because their child has been expelled from several child care situations. The EI/ECSE provider said that “once we start digging into it, we can determine that there are more mental health issues rather than just strictly behavioral issues, or the mental health issues are manifesting behaviorally” (002, 9). Although

children were most often made eligible for services through developmental delays in communication, cognitive or other domains, these delays were often understood to be related to chaotic family situations. Communication delays, the coordinator noted, were sometimes related to a lack of interaction between parents and their young children, when parents were withdrawn because of depression or other mental illness. The EI/ECSE provider reported that the agency would make a child eligible whether or not the probable cause was environmental. "It doesn't feel right to us to say, well that's not a special ed issue," he said, "even though the child is showing a delay because the parent really needs to talk to the child more. If the parent has legitimate barriers and they can't do that because they are struggling with mental health issues, then we are going to get them in and work with them, and at least have some other adults keeping an eye on this child and giving the parent some ideas of what to do to help the child along. And maybe even make some referrals to the parent so they can get some extra help too" (002, 10).

The EI/ECSE provider identified a trend that about one-quarter of the families were self-disclosing in the eligibility process that they had a mental illness or serious mental health problem. The eligibility team asked a standard question of all families about family history of mental illness, neurological issues, or learning disabilities. "Very often," he said, "we'll get parents who say I am struggling with depression, anxiety, bipolar disorder, I am being treated for this or that" (02, 9).

The provider reported that behavior specialists, as part of the educational system, did not provide mental health treatment to children or caregivers. He stated that children with serious social-emotional problems were referred to the county mental health program or to a few private providers while they were also receiving services from the

EI/ECSE agency. However, he felt that children often received a more comprehensive team approach and holistic perspective through the educational system.

This EI/ECSE agency had for many years offered parent support as an integrated part of services. Parent groups were run by behavior specialists or other staff to bring parents together for training, to answer questions, and support each other. The agency provided areas in each community setting that were set aside as meeting places for parents. They were made welcome with lounges where they could do research and meet other parents. “Years ago,” the EI/ECSE provider explained, “people felt that it was really important to give parents a place to connect and a place to go talk to other parents and share some of their concerns for their child, or to ask questions and to gather information. So it has worked out real well over the years. I just wish we could do more of it” (002, 15).

Parent groups were provided during the time that parents were scheduled to bring their child in for a monthly toddler or EI intervention group. The parent groups were currently scheduled monthly and could run the whole year. The curriculum was designed around the specific group focus, whether it was on motor issues, behavior problems, or learning about child development and parenting in general. The groups were intended to be training sessions for helping parents work at home with their children, but encouraged parents to bring in their own issues, and parents were encouraged to participate as much as possible.

Parent groups were provided for all families enrolled, but mostly served families with children birth to three. There were fewer groups for parents whose children were in the three to five range since their children were mostly served in classrooms, but there

was almost always a core group of parents of older children who like to attend the meetings. Parent groups were been run by behavior specialists and other EI specialists who were comfortable with issues parents might bring up. “A speech pathologist might run a parent group where communication development is the biggest concern. A speech language pathologist might feel real comfortable talking with parents about other issues that they might bring up, like sleep or feeding, or behavior, or whatever else might be going on” (002, 5).

This agency has built high quality services that meet many of the needs of children and families with mental health problems through behavior specialists, highly experienced teachers and home visitors, and parent support. When asked how children and families with mental health issues could be served better, the EI/ECSE provider began by identifying a change needed in the way evaluations are done. “On the one hand I’d want to beef up the evaluation part of it, so at the front end you’d get a really great evaluation that guides services” (002, 13). He would also like to have mental health and social workers working alongside their staff. He would like to see a parent be able to come in the agency and meet with a social worker or mental health counselor in a model similar to Relief Nurseries. He expressed a dislike for the labels such as behavior specialist and mental health specialist. “It just would be really great to have in the early childhood arena, special ed arena, people who are really familiar with infant mental health issues, young child mental health issues and treatment, family-centered treatment and be able to provide those services at the same time that you have a child in a preschool classroom where they are learning those skills to be successful in a group setting. That would be absolutely ideal” (02, 13).

Vignette 4: A Prevention Model in the Community

Being proactive is what we're really about in terms of going out to other programs to help them put into place different strategies that might reduce behavior problems that they are seeing, and improve communication, and supporting them in their teaching practices. (008, 12)

The coordinator of a medium-sized, rural EI/ECSE agency and two of her EI specialists were well trained in behavior management and social-emotional development. Her agency was too small to employ behavior specialists, so this role was taken by skilled staff. The coordinator had a background with emotionally disturbed children in a variety of settings. The agency was able to offer its expertise to the Head Start and Oregon Coalition for Child Development preschools that their children were placed in. This occurred regularly in monthly meetings when EI/ECSE staff met as a part of the team in community preschools. "We will sit down with teachers and their staff to talk about actual kids that are on IFSPs that are in their program," explained the coordinator, "to share information, and talk about different ways we could be supportive to them, every kind of aspect" (008, 11).

The help for behavior management extended beyond the children on IFSPs that they were responsible for. The coordinator reported that because her staff were frequently in the agencies, the preschool staff could approach them anytime they had concerns about children's behavior, whether or not the child was served by EI/ECSE. "We will take the time to observe and support them," she said. "We've done a lot of work this year around trying to help them to get good visual schedules up in the classrooms, so kids can anticipate transitions and have a better idea of what's coming and what to expect. Just improving communication with kids, too" (008, 11).

Other preschools in the community also called on the agency when they needed help with children with challenging behaviors. “I can see that the regular community preschool programs probably utilize us more than mental health if they’ve got children with behavioral concerns,” she reported. “They consider referring to us, and we will go and do an observation or screening” (008, 2). Often the child wouldn’t qualify for special education services, but the EI/ECSE staff would still provide consultation to the community preschools to support them in strategies for working with kids with behavior problems, and to help them assess if the child needed a referral to mental health.

One of the strengths of the EI/ECSE agency was that its staff met together frequently. The agency had a small enough staff that they could have all-staff meetings weekly, and they used them as a source of information sharing and support about children and families in the program. The coordinator described them as a kind of “decompressing,” when people could have the opportunity to talk together and help each other. They used the time to do supportive team activities as well. “With this staff so far, that seems to be really effective,” she reported. “All the staff come to the meetings, including instructional assistants. We are kind of like a family, in a way” (008, 10-11). Before she took the job as coordinator, she worked for a very large agency in which staff worked independently. She came to understand that the weekly meetings were a critical component of communication and support for staff. “We are in people’s lives all the time,” she said, “and to kind of keep that balance with yourself and your professionalism we need to have opportunities to support one another. It really works well” (008, 10-11).

The agency had a strong focus on supporting children’s social-emotional development. It offered parents and other providers classes on conflict resolution. “We

put a lot of focus and energy into working in our program and with community preschools,” she explained, “in supporting kids’ social-emotional development by helping them learn how to communicate and problem solve” (008, 11). She found that adults who wanted to jump in and fix problems for children needed a lot of support to learn that social-emotional skills need to be nurtured over time.

The agency’s need for mental health services was reported as minimal at the time of the interview, in terms of children whose social-emotional issues couldn’t be addressed through staffs’ own interventions. However, the coordinator believed that her staff was limited in how much support they could offer families. She would like to have mental health integrated into the services she provides, in the same way that other related services such as speech or physical therapy are available to staff and families. “To not have somebody that’s a specialist specifically in mental health, that’s at least part of our team intermittently, always does seem a missing link,” she observed (008, 3).

The coordinator would like to have the same type of proactive support from mental health that she and her EI specialists give to preschools in the community. She identified a need in her own agency of meeting the needs of parents who have a history of drug addiction, or have chaotic lifestyles and few resources. She provided a story about a family that she was particularly concerned about.

I’m thinking of one family, young single mom, with two little ones that have both been identified with special needs, and she’s pregnant. So that’s a tough situation. They live in a pretty bad living situation. It’s pretty neglectful. So having somebody to kind of bounce that off of and who might give us some additional tools beyond our tools. I mean that parent is making progress, and the kids are making progress, baby steps. And maybe that’s just the best we can do. But sometimes just having another expert in that area to be able to share ideas and bounce ideas off I think is just critical. And that, like I said, is how we support each other in the program. So to have another expert that addresses that other aspect of children and family development I think would be awesome. (008, 12)

CHAPTER V
STATE-WIDE STUDY: MENTAL HEALTH SERVICES FOR
CHILDREN AND FAMILIES IN THE EI/ECSE SYSTEM

Introduction

Chapter 5 addresses Research Questions 4 and 5 by investigating the perceptions of EI/ECSE and mental health personnel about how well their communities are meeting the mental health needs of young children and families. This research study has a focus on EI/ECSE agencies, and for that reason the information gathered from mental health agencies will be examined from the perspective of how well they are meeting the needs of the EI/ECSE system. However, in a discussion about how EI/ECSE and mental health agencies work together and perceive each other, it is difficult to separate their perspectives into discrete sections of the chapter. Their perspectives will be intermingled throughout as interview themes are discussed.

Before examining perspectives about mental health services, a summary of EI/ECSE providers' recommendations will be provided. They will be examined again at the end of the chapter in light of the issues raised.

Summary of Recommendations from EI/ECSE Providers

The sense of needing to partner with mental health is expressed in a simple statement made by several of the EI/ECSE providers: "We're not mental health

therapists. Education and special education were never meant to be in the mental health field. So we definitely need their experience and their knowledge” (020, 8).

Recommendations from EI/ECSE providers of how they would like to see a mental health perspective integrated into their work had a variety of themes. While some of these recommendations have been previously provided in the context of reporting EI/ECSE needs and strategies, they will be summarized here to provide an overview of the issues.

First, many agencies desired more mental health training for their own staff. The focus of training included understanding social emotional development related to children with disabilities, recognizing signs of early mental illness, more training on working with behavior problems, and strategies for working with children with severe mental health disorders.

Next, EI/ECSE providers expressed a need for educating parents on the mental health needs of their children. This extended to training EI home visitors to coach parents in responsive interactions and support for relationship-based work with parents.

Third, several providers desired a social worker to be employed by their education service district to help families obtain community resources. Finally, the majority of EI providers desired some kind of direct collaboration with mental health, in which a specialist or consultant worked in their agencies providing training for EI/ECSE staff and therapy for children and parents. These recommendations are summarized in Figure 4.

As has been discussed in the previous chapter, none of the EI/ECSE agencies had a partnership with a mental health provider to the extent that they were able to access mental health consultation on a regular basis except Multnomah county. This county

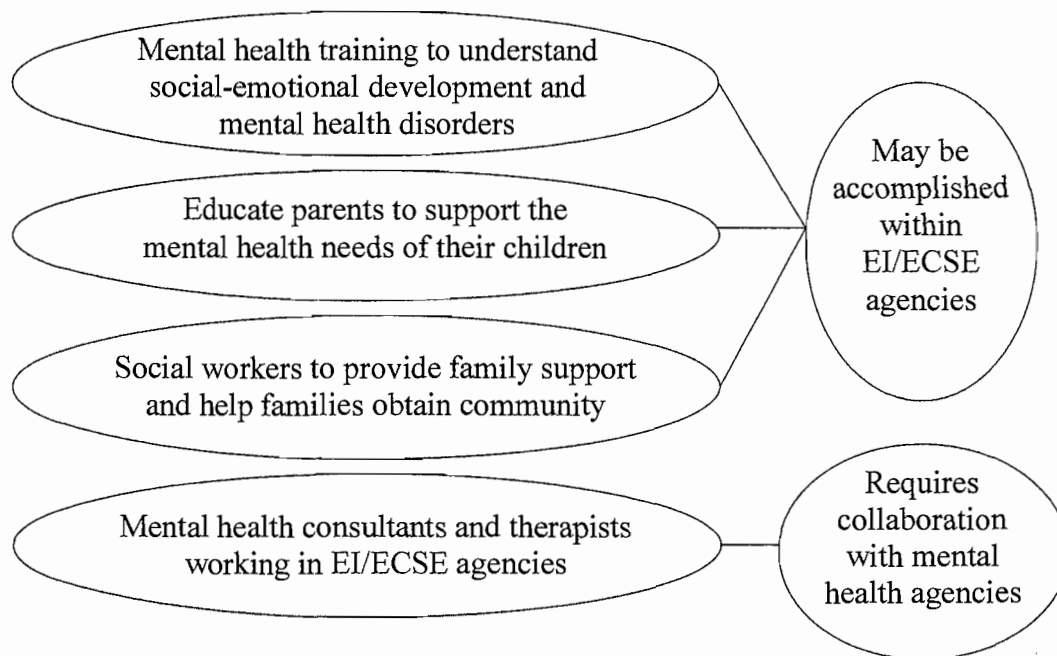


FIGURE 4. Summary of recommendations from EI/ECSE providers.

provided a key lesson about how mental health consultation for early childhood agencies could be developed and supported through collaboration between county agencies. The elements for building collaborative relationships that appeared in the conversations with other EI/ECSE providers will be examined next.

The Importance of Working Relationships

The Multnomah county mental health consultation program has been able to sustain itself for many years. The Associate Special Education Director described the years of planning in Multnomah county that had contributed to their being able to offer

comprehensive mental health support to children. She described their work as a long-term cooperative process among many partners who advocated for best practices in mental health. “I wouldn’t put anyone in the driver’s seat. It’s more everyone sitting around the dining room table having dinner together” (003, 8).

She reported that the county partners had worked for years through the Early Childhood Council of the Commission on Children and Families to develop an early childhood framework that specifically addresses young children’s mental health and families’ stability. She believed that the county had been able to do remarkable things to support children because of its ability to make a comprehensive plan that was followed by all of the partners working for children. People had developed strong relationships and knew each other through years of working together. “It’s about how we as a whole group living in this area want to work together with a focus on kids and families,” she explained. “So you don’t find a separate six-year plan from what Wraparound Oregon is doing in their planning process, that is different from the early childhood framework, or the school-age framework, or the Poverty Advisory Group’s framework. What you find is everybody looks at all of those things to develop something that is truly comprehensive and makes sense. I would put it even at a higher level than cooperating, actually saying “how do we do things differently?” (003, 7).

In the study, EI/ECSE participants in other counties described how services in the community collaborated to inform each other of available resources, to find immediate services for children, and to plan together to improve services. This theme of collaboration was a powerful issue that ran through interviews with many EI/ECSE

providers in regions that had close relationships with their county mental health agencies, and is likely a pivotal issue in working on the recommendations EI/ECSE providers have for improving services.

Collaborative Working Relationships

In the interviews with EI/ECSE agencies and their county mental health agencies, a variety of working relationships emerged. The first kind of relationship could be characterized as a close working relationship in which EI/ECSE described its mental health partner as a well-known, close collaborator in trying to meet the needs of families and children. This kind of relationship was confirmed in interviews with their local mental health providers, who spoke of EI/ECSE as an important community partner.

A close working relationship appeared to be well functioning in a little less than half of the EI/ECSE agencies in the state-wide study, in five counties and one Indian reservation. The relationship often appeared to be based on personal relationships of people who worked directly together and spoke complimentarily of each other's efforts.

One rural EI/ECSE provider saw herself as fortunate to be in a county that had been able to maintain a high functioning mental health agency that was service oriented. "My experience for the region, when I worked over at county mental health," she said, "was that we are not the biggest county in our region, but sometimes we had a child psychiatrist when a bigger area couldn't bring one in. So we've really been lucky in that regard.... I think we always want more, but I think we are very satisfied with their work. I mean if you've got people whose intentions are to help, and who will do everything they

can do to find a way, if there are barriers, you just can't do better than that. They'll work with you, and you are working with them. You usually can find a way" (014, 7-8).

This kind of relationship existed not only in counties that had adequate mental health services, but even in those in which mental health services were stretched too thin. Two of the three EI/ECSE providers interviewed in frontier counties worked closely with their mental health providers in communities that had built close collaborative relationships out of necessity because of the lack of services they all faced. In one of these counties, the EI/ECSE coordinator was also the director of Head Start and served 75% of the three- to five-year-olds in her county, so she represented a large part of the early childhood services. She had a close working relationship with other community agencies and a high respect for the mental health director, who she described as "very collaborative, out in the community," but struggling with fulfilling the community's mental health caseload. The EI/ECSE coordinator related that because of the limited capacity of mental health she referred only children with severe problems. "He tries to meet the needs of the community, but funds are pretty limited and he's pretty stretched," she reported. "Actually all the staff are stretched. Trying to find a qualified mental health counselor for young children is very difficult" (010, 1). The mental health director in her county described how his agency shared information back and forth with the early childhood program's coordinator and teachers. "A lot of time they will do developmental screenings at the early childhood center," he said, "and we will incorporate those into our mental health assessment. And when some of these kids are really at risk, the Head Start staff may be part of our Community Resource Team meetings and help us with the

planning around that. That is typically how it goes. We are a very small town, so we know them very well, and they know us very well” (026, 2).

On an Indian reservation, an EI/ECSE provider described work with a single qualified mental health therapist who was employed by the Tribal counseling center. The EI/ECSE provider was a behavior specialist who worked in the classroom with children and referred to mental health when she saw emotional problems in families. She had referred about one-fifth of the 40 ECSE children she worked with for counseling. “There’s a counselor there who we like to use, who comes into the school and provides counseling,” she reported. “And, you know, we have now a really great relationship with this therapist. In the past, I’d say maybe it was two kids, tops. But we’ve really built up this relationship with the therapist that we know here, so we recommend her to parents, we call her in, she comes right here. We have a provider room for her to work with the child in, and so it’s also the connection that we’ve kind of built over the last few years” (018, 4). This EI/ECSE provider felt that early childhood mental health services weren’t yet adequate, but that the close relationships were vital. “I think we are getting there. I think it is something we are starting to pay more attention to. But it’s not enough, I mean it’s also not enough. We’re all trying with what we have” (018, 6).

As mentioned earlier, cooperative, close relationships appeared to be working in only half of the agencies interviewed. A less productive kind of relationship was observed to be occurring when EI/ECSE providers primarily characterized the capacity of their local mental health system as deficient, or expressed a lack of knowledge about how services operated. These relationships could be characterized as a “poor” working

relationship for the purposes of this study. These characterizations are very broad impressions based on only a few interviews. They have been made solely on how agencies talked about each other, not on actual personal relationships individuals in one agency may have had with those in another, which are unknown to this author. They are not intended to label the actual working relationships of agencies, but to discuss general theories about how agencies appear to work together.

“Poor” Working Relationships

One EI/ECSE provider characterized the mental health services in her county as inconsistently staffed and inaccessible. “I don’t think we have access to good mental health out here,” she said. “We have a high turnover. It seems like I will have a child and he will have one therapist, and then a week later they’ve got another one, and then a week later there is somebody else involved. Definitely we don’t have smooth transition, nor do we have consistency for the families” (025, 1). She reported that her agency attempted to arrange referrals and support families in getting into services, but that families often met a significant barrier in mental health’s centralization of intake in an urban area that was a long distance away from where most of her families lived. “The majority of the families that we are working with, especially in this area,” she explained, “are migrant Hispanic families and families with lower incomes that don’t necessary have the means to drive there” (025, 1). When families did get through intake, she reported that they were discouraged with the agency’s lack of consistency and resources. She said it was not unusual that “the families go in once and then they become very upset with our mental

health services available to us in this county, and then it becomes a bad word and they have already dealt with that organization. It's a real challenge for us out here" (025, 5). This provider's story was one of the most disheartening in the study. In other cases in which working relationships appeared to be dysfunctional, the causes were more subtle.

One EI/ECSE coordinator in a large urban agency spent a portion of the interview talking about how difficult it had been to communicate with the county mental health system, even though she attended early childhood coordination meetings with mental health and other providers. She was highly experienced and had a thoughtful understanding of the growing problem of children with severe mental health issues in her services, and of teachers' need for training. She envisioned a closer collaborative partnership with mental health in which they actually worked side-by-side with her staff. "I'd really like to see a live body that is actually here part-time helping us figure this out" (020, 7).

Several community mental health participants appeared to view EI/ECSE as such a small player in their county that they didn't even recognize EI/ECSE as a referral source. For example, in one county, in separate interviews the EI/ECSE provider and mental health provider both reported that they were developing their programs to work with evidence-based therapies for parent-child relationships. It appeared that the two agencies had parallel interests that were philosophically aligned. The EI/ECSE provider was well-versed in one of the therapies used by the mental health center to the extent that she could analyze the characteristics families must have to qualify for being referred for the therapy. She mentioned by name one of the counselors she respected and referred

families to. In contrast, the manager of the child services at the mental health center, albeit in a short interview in which there was insufficient time to go deeply into issues, stated that her agency did not receive referrals from EI/ECSE, and she was not aware of whether her agency had much interaction with EI/ECSE at collaborative community meetings.

In a second instance, two EI/ECSE agencies in neighboring counties were served by the same public mental health program. During the interview with the mental health provider, she reported that the agency had for years had a contract for mental health consultation with early childhood agencies in the two counties, including EI/ECSE. Yet neither of the EI/ECSE agencies mentioned receiving mental health consultation and described that they had little interaction with the mental health agency except in referring children who had severe mental health problems.

In a final example, the EI/ECSE provider for a large agency had extensive knowledge of the mental health system through his work for over 15 years in the same county. He was familiar with the skill level of therapists and referred children and families regularly. A mental health therapist from the county mental health agency reported that her program had worked closely with the EI/ECSE agency and other early childhood programs in the past. She said that in the economic downturn that Oregon experienced after 2001, her agency had such severe budget cuts that it laid off therapists and withdrew from all community work that wasn't essential to operations (030). It appeared that the loss of this collaborative link had deteriorated their relationship to the extent that the EI/ECSE agency was no longer recognized as a significant source of

referrals by the current supervisor of the child and family program. When interviewed, he reported that although his agency had a focus on serving young children, and served many children starting at age 3, he believed that his agency received an insignificant number of referrals from preschools. “It’s certainly not that we wouldn’t work with that population,” he said. “But I’ve got to be honest, it’s not a population that gets discussed a lot. I mean we don’t get calls from schools saying, “I have a 3- and a 5-year-old.” It’s not even on the radar” (017, 7).

This mental health agency had developed an extensive program of therapists in the county’s schools, placing therapists in schools that were most in need. The program director explained that many of his referrals for young children came from elementary schools in which they had therapists several hours a week, or from parents of school children who knew about the therapists. When asked if his agency would provide consultants in EI/ECSE classrooms, he responded that he would if there were enough requests.

The fact that the mental health supervisors in these interviews were not aware that EI/ECSE referred many clients indicated the lack of a face-to-face relationship at the administrative level. EI/ECSE providers were able to identify specific skilled therapists and were likely communicating with therapists directly. However, the kinds of collaborative relationships in which decisions are made about allocating resources did not appear to be functioning well.

Several EI/ECSE and mental health providers offered their opinions on why there wasn’t better collaboration between child-serving agencies. A mental health provider

who was interested in building community collaboration speculated that collaboration was not occurring as often as it should be because each agency was trying to meet its own individual needs. “There isn’t as much funding and time for collaboration than is probably needed,” she explained. “And I think one of the big challenges for anybody, anywhere providing services to very young children is how to do that adequately. And I don’t think we do” (006, 13). She thought agencies not only devoted inadequate resources to collaboration, they probably needed training in how to collaborate, “even the mechanics of how to collaborate effectively,” she suggested. “Because children’s development is so interdependent and interrelated, and the way each agency is funded doesn’t allow for that, really. It may not just be the time, but maybe more the logistics of how to make that happen effectively. And I hope we learn more about that, because I think it is a recognized issue” (006, 13).

Concern for collaboration sometimes focused on specific populations of at-risk children. Several EI/ECSE providers focused their concerns on children they served who were also in the foster care system. Maltreated children cross several systems and are particularly vulnerable. One provider felt that these children’s needs were not being met in a holistic way and that they often got lost in the system. “I think if we could strengthen what services and supports those kids have access to, in collaboration with all the collaborative partners who also support those kids, that would make a long gain for the kids that we serve in EI/ECSE who are also foster kids” (005, 13).

The cases in which an EI/ECSE agency was critical of, or had little contact with its local mental health program was not always related to mental health’s capacity to

serve them. It was often the case, instead, that EI/ECSE agencies spoke unfavorably of mental health services when they did not work in close collaboration and see each other as partners in improving services for children and families.

These issues related to the theme of working relationships between mental health and EI/ECSE agencies is summarized in Figure 5.

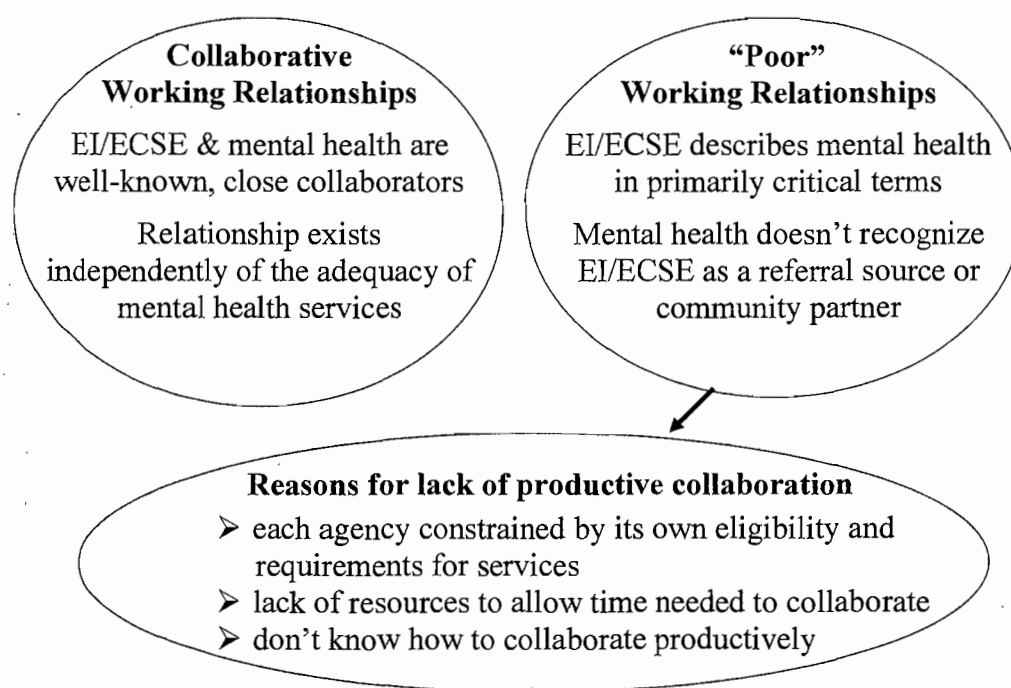


FIGURE 5. Kinds of working relationships identified between EI/ECSE and mental health agencies.

The Capacity of Mental Health Agencies to Serve EI/ECSE

The majority of EI/ECSE agencies in the statewide study (i.e., 10 out of 15) reported that generally their local mental health systems did not have the capacity to meet their needs. These opinions were not based on their ideal-world recommendations, but on

the capacity of mental health agencies to serve the number of children and families that they believed needed services. Lack of capacity included difficulty in staffing, an overburdened system that responded primarily to people in crisis, lack of services for children who were not Medicaid-eligible, and insufficient services for parents to work on their own psychological issues that affected their parenting. The issues identified in interviews are summarized in Table 11 and will be discussed in greater length below.

TABLE 11. Problems in the capacity of mental health agencies that become barriers to services for EI/ECSE children and families.

Hiring and Retaining Qualified Providers
<ul style="list-style-type: none"> ▪ Not enough skilled therapists ▪ Not enough psychiatrist time ▪ Not enough basic staff such as in-home skill builders
Gaps in Services for Children
<ul style="list-style-type: none"> ▪ Focus on crisis cases ▪ Geographical barriers ▪ No insurance = No services
Limited Services for Families
<ul style="list-style-type: none"> ▪ OHP doesn't provide enough adult behavioral services (Families can receive limited services through child's OHP) ▪ Families who need services most are most difficult to get into services <ul style="list-style-type: none"> ▪ Transportation challenges ▪ Committing to therapy ▪ Resistance to being seen as having difficulty with parenting

The dissatisfaction among most EI/ECSE providers was not often related to the qualifications of therapists, except in a few cases. Before reporting on the problems in capacity that were identified by participants, it would be helpful to present a perspective

of the quality of services that mental health agencies reported they could offer children, and some of the constraints they were facing.

Serving the Early Childhood Population

A majority of county mental health agencies in the state-wide study reported that they served children in the birth to five age range (i.e., 7 out of the 10 programs interviewed). Providers from these mental health agencies described competent early childhood services that they believed were meeting the needs of their clientele. There was large variation in the number of early childhood therapists available in each agency, from one specialist to a team of therapists.*

For example, in a rural county with a small mental health agency, one or two therapists had a specialty in early childhood. Through a state grant from the Oregon Children's Plan, one of its therapists had been working part-time as a mental health consultant with the early childhood programs in the county. "I am kind of it," she explained. "I have a couple colleagues who also do children, one in particular that does young children like I do. But there's not a formal team....I think that right now the county mental health system is pretty strong for young children. I am here and available to take children any age, but birth to 8 is kind of my key strength. I have some, I wouldn't say expertise, but a little more knowledge in that area. Our child psychiatrist adds a really nice complement to early childhood, and she has a special interest in early childhood too. So I think our ability to serve that population of children is really good" (015, 2).

In another mental health agency in an urban area in a largely rural county, the manager of the child team stated that services to young children under five was about 10-15% of the agency's work. She described her services in terms of what she felt was an excellent capacity to do evidence-based work in early childhood. "We have a few therapists here who are familiar with the *DC 0-3* and, you know, are pretty experienced at working with the really young ones," she explained. "Obviously we are a medical model and we do have to provide a diagnosis in order to provide any services. But from there we are able to provide Responsive Teaching and/or Parent-Child Interactive Therapy (PCIT) to families with young children....Responsive Teaching is a way of organizing and looking at the areas that a child has deficits in and to provide the parent with some information and training for meeting the needs of the child" (029, 1). This agency had expanded its use of the evidenced-based therapy PCIT through a state Oregon Children's Plan grant, and was using the grant to expand consultation with community early childhood programs such as Head Start.

A third mental health supervisor described how her agency had recently developed a team of several therapists specializing in early childhood. "I know that I was hired as a supervisor in part because of my experience with early childhood, because that was a priority," she related. "The program manager specifically wanted someone who had training and expertise. So there is an emphasis and support for that" (006, 16). She stated that she had been able to build the team with the help of a state Oregon Children's Plan grant. "Having the Oregon Children's Plan grant," she related, "gives us flexibility to develop services, that without would be really challenging. Because we get paid to see

kids. Oregon Health Plan pays us to see kids, not for community development, you know, collaboration kinds of things. The grant has been extremely helpful just in giving us the flexibility to do that” (006, 16). The need for supplemental sources of income such as state grants, outside of the Oregon Health Plan funding, was a common theme for agencies trying to develop early childhood services.

The early childhood mental health provider in the last example described the difficulty that early childhood practitioners have found themselves in since the Oregon legislature directed the Department of Human Services to spend increasing proportions of public money on evidence-based treatments (Oregon Department of Human Services, 2008). She contrasted the few evidence-based therapies available in early childhood to the qualities of therapies she felt were needed in work with very young children. “One weakness in our system is there are not a whole lot of evidence-based practices with young children....So that puts some pressure on us to some degree in what practices we can choose for young children,” she explained. “We are continually looking for additional mental health practices that will meet evidence-based standards.” She went on to explain that the therapies she believed should be used with this population focused on the parent-child relationship. “When you are talking about young children and mental health,” she said, “the caregiver is really an integral part of that. For young children, the caregiver is at the center of their world. So a lot of infant mental health is working with parents, often helping them soothe and connect with their child in different ways” (006, 12).

In several cases, EI/ECSE providers praised their mental health agencies for the quality of early childhood specialists, while at the same time reporting that the agency lacked the capacity to serve their referrals. Their mixed satisfaction can be summed up in the highly complimentary words of one EI/ECSE provider in a large agency. “Locally they have got some extremely skilled therapists, some people who have become experts in infant mental health, some really, really strong clinicians. So I think that’s a huge strength,” he said. “I am confident that they will get good treatment with the skilled people. Not confident that they have enough skilled people and enough capacity to deal with all the referrals that we make” (002, 16).

It should be noted that a few EI/ECSE agencies in the study reported difficulty in referring children because their mental health agencies did not employ anyone who specialized in early childhood. One EI/ECSE provider explained that the available therapists didn’t really understand how to work with young children. “I mean, we can send kids up there, and they will provide the services,” she said, “but the kids really need someone who understands the age level and can communicate at that level, and we don’t have that. So they do get counseling, but it is probably not age-appropriate” (010, 1). This EI/ECSE provider noted that her Head Start had to hire an expensive mental health consultant from the nearest urban area because an early childhood consultant wasn’t available locally (010). Yet, some of the EI/ECSE providers in remote counties were sympathetic about the lack of therapists who specialized in early childhood. “I am putting on my administrator hat here,” one provider in a frontier county said. “I’ve got three families who need behavior services. How does that justify salary benefits of anybody? In

defense of mental health, when they get a therapist, it's got to be somebody who can serve people from birth to death, because that's the need. And I think that's really a hard thing for them to try and meet" (016, 9).

Both EI/ECSE and mental health are public agencies operating under large constraints. A particularly strong example of the same constraints under which EI/ECSE and mental health providers worked was seen in a large, isolated rural county. In the large EI/ECSE agency that served multiple counties, providers reported that services suffered from chronic lack of qualified EI/ECSE specialists and instructional assistants to work with the high behavior and mental health needs of children in their programs. They also reported that the mental health system had an unacceptable degree of therapist turnover, a shortage of early childhood specialists, and a very overburdened system. In contrast, when the mental health supervisor was interviewed, she described how she was building an early childhood team, even in an agency in which most therapists preferred to work with adults. She saw herself as an advocate for the unique issues of working with young children. "What I would like to see is better understanding from management of the differences in serving young, young children," she said. She worked with providers who had no training in medicating children. "They focus so much on adults," she explained, "that I feel like I have to constantly say, 'But that doesn't work for kids.' And then I need to be saying, 'OK, this might work better for kids.' Really trying to force two different segues, making sure we're providing the best resources for kids and not pretending they are just mini-adults" (023, 9). She felt, personally, that she was making progress in

building decent services for young children within a system that was struggling with the overload of clients and lack of trained therapists.

Hiring and Retaining Qualified Providers

The problem of hiring qualified mental health personnel was an issue that was raised by both EI/ECSE and mental health providers. An EI/ECSE provider explained the problem as one that was of particular difficulty in rural areas. “One of the issues that you probably realize whenever you start to look at rural,” he explained, “is you have fewer people who have a knowledge base in certain areas, especially a highly specialized area....I think it is good to know that in rural areas, capacity is a tremendous issue for us” (014, 12).

In some rural counties, mental health staff were long-term employees, but the problem lay in the limited number of providers in small county agencies. An EI/ECSE provider in one of the frontier counties reported that she had very few mental health providers. “We have a psychiatrist, of course, that comes one day a month, a child psychiatrist. I don’t know where he comes from. We have a psychologist that does play therapy and sees kids who live here. And we have a social worker. She comes in and does the mental health observations for Head Start, and she heads up the intensive treatment services for all the kids in the county. So there is our team of three for the county. And they are also doing...I think the psychologist is doing adult treatment as well. The psychiatrist just comes in and writes prescriptions and leaves. Sees kids for a ½ hour a month. And that’s kind of the core team” (019, 7).

In one of the regions with the most extreme problems, an EI/ECSE provider in a large agency described the effects of the understaffed mental health system on children in her program. “They are like any other agencies that are in rural areas,” she said. “They are so overwhelmed with the level of service they have to provide that some of these kids are getting minimal at best. That’s the sad thing because some of these families and kids need more than they are receiving....I am working directly with two counselors right now, and they are so overbooked that even though the plan says they should see and counsel these kids once a week, sometimes they see these kids for possibly 10 minutes every 2 weeks, or sometimes don’t see them at all for a month at a time, especially if you are dealing with families that we are dealing with, who have work issues. We have a lot of shift workers. There tends to be a lot of missed appointments” (028, 1). She described how thinly stretched her county mental health services were. “We are such a rural area that we are limited to access with specific facilities where they can help us with counseling,” she explained. “What’s happening is, the physician that comes up is working between Oregon Health Sciences University, and then also from one of the hospitals in Seattle. So they only come down once every three months. There is a nurse practitioner who is on call monthly. But it is so far out that they are having to book appointments to be able to be seen. I know that I have kids who are waiting at least three to four months at a time” (028, 1).

In another region that had difficulty retaining staff, a mental health provider in a large agency that served multiple counties was trying to expand her services with in-home parent support staff. She described the difficulty of finding and retaining basic

qualified staff. “One of our problems in this area, a huge problem, is not the lack of money so much, although you’ll hear that. It’s the lack of providers,” she explained. “There’s just not a lot of people that are trained to be able to go into homes, or are trained and can pass a background check” (025, 5). She cited the lack of employment agencies that were taken for granted in metro areas. “It’s the less trained staff that tend to turn over a lot here,” she said. “But it is always an issue of getting qualified people in this area, and retaining them....I don’t have another single agency, like you do, for instance in the metro area, where you can call up and say, ‘I need a parent trainer, I need someone who can go into the school.’ We have to develop all of that from scratch. That’s a huge issue” (025, 5).

She identified in-home parenting services as an area in which mental health and child protective services had a crucial deficit in personnel that was directly related to children’s mental health. Philosophically she believed that this service could prevent much larger mental health problems in children if more in-home services were available. “We have a lot of drugs, a lot of meth in families,” she said. “We have a big Hispanic population in one county. We have tons of parenting classes, but many people who need parenting classes won’t go to parenting classes. What they really need is in-home services....I’ve been in conversations with the local [child protective services] people about providing in-home services, and they do to a small degree, but not really to the intensity that it’s needed....if they could provide services in the home, and that includes mental health services, but also safety services, then we could keep more children in the home and we could do a better job for providing for the needs of children. I really think

when [children are removed from the home], we've just created mental health issues. You've traumatized children, you've created sometimes lifelong issues with these children that we could prevent early on" (025, 7).

She also described the difficulty of finding and retaining therapists skilled in early childhood. Her agency had difficulty even when they had tried to re-train permanent staff. "Another issue that we are working on quite intensively is getting people trained up at the master's level to provide services for early childhood. ... there's just not very many of them around. And we've talked a lot about sending a therapist from our agency to get certified in early childhood, but retaining therapists here is hard anyway, and we just haven't had any success in getting anybody that wants to travel 80 miles one way for a class as well as hold down a full-time job. Just getting those providers is an issue out here" (025, 6).

As has been shown, finding and retaining mental health staff at all levels is a serious problem in some parts of the state that contributes to the inability of EI/ECSE providers to refer children with mental health problems. A second problem related to the capacity of mental health agencies focuses on the gaps in services that prevent a large proportion of EI/ECSE children and families from being referred. These and related problems will be discussed next.

Gaps in Services for Children

Three gaps in mental health services for children were identified by both EI/ECSE and mental health providers. First, community mental health providers that served

Oregon Health Plan clientele were identified as primarily serving crisis cases; children with less severe needs were less likely to be served. An EI/ECSE provider in a large agency expressed the reservation that the local mental health agency prioritized children who were in crisis. “We try to refer those kids to the mental health system as much as possible,” he explained. “The problem with that is, the child and family programs around here are also operating on kind of a crisis orientation, where they will take kids and families who are in severe crisis, but they won’t have capacity for working with kids who aren’t in crisis and just simply need some ongoing work” (002, 4).

The focus of the bulk of services on crisis cases was confirmed during an interview with a large mental health provider. When he was asked whether his agency specialized in kids who have more serious mental health concerns, or if children with less serious problems could be seen, he replied, “Well, we do both, but we are more likely to see the more severe kids. Obviously OHP is our mandate, so we see Oregon Health Plan kids. That can run the gamut from kids who have very serious problems to kids who may have an anxiety disorder or something not quite as intense. But we see all of them. I mean, that is our mandate” (017, 1).

Second, mental health agencies in rural areas were located in the highest populated areas of their counties. Many agencies did not have the capacity to provide services in far out-reaches of their catchment areas. One mental health provider explained that her agency served the whole county, but services were limited. “The people in the way outskirts are probably poorly served. They just are. I don’t make home visits, you know, 60 miles out” (015, 3). This fact was difficult for some EI/ECSE providers to

understand because their programs are mandated to serve all eligible children. In more remote counties, this was often done by home visiting over long distances. One EI/ECSE provider reported that he routinely drove 250 miles round trip on his circuit to serve families all over the county.

Some mental health agencies opened offices in different parts of remote counties, but then the problem of privacy was activated. One EI/ECSE provider told how his families were unlikely to access a mental health office in their town in which a branch office had been opened by mental health. "The county mental health office is in the biggest town," he explained. "I believe they are trying now to do more in the north end of the county. But it's in an office where five or six other agencies are located. And it's also a small community up there, so certainly confidentiality-type questions are in play there. You walk in there and see five other people that you know. There might be your neighbor. I think that can play into a family not wanting to go up there" (016, 2).

Third, many EI/ECSE providers referred to a gap in services for a large group of families with no or inadequate insurance. In the following description an EI/ECSE provider in a large agency referred to problem-solving with public health to get her needs met. "Mental health only works with kids who are on the Oregon Health Plan, and that's only half of our kids. So that's a real dilemma," she said. "We work with our public health nurse, who is really smart in trying to figure out ideas. But there's not much out there. We try and limp along and do the best we can, and hope the kids make some progress. But, boy I'll tell you, it is not much" (011, 6). Another EI/ECSE provider in a large agency expressed his concern about children who were not covered for mental

health services. His agency gathered information about insurance coverage during the intake process and were aware of a large number of families who had none. “The local community mental health agency is really focused on kids who are covered by the Oregon Health Plan because that is their contract,” he explained. “And people with good insurance or other private means can go into a private office in town. But what about that growing number of people who don’t have any health insurance whatsoever? They don’t qualify for OHP, but they don’t have private insurance, or they don’t have private insurance that is sufficient to meet their kids’ needs. Then there is nowhere to go. And that is a huge, huge problem. The mental health agency has done sliding scale work in the past, but again when the capacity isn’t there, you are going to be focusing on the most serious kids, or the ones with Oregon Health Plan coverage. I don’t have any data on that myself, but I understand that it is a huge and growing number” (002, 17).

From the perspective of mental health, this gap in services was also seen as a problem. Mental health agencies had a variety of ways of incorporating services for families with no insurance. In one frontier county in which the community mental health program was the sole mental health provider, the director reported that his agency took all forms of payment. However, he worried that some families with young children still didn’t access services because of the cost. “You know I think sometimes they may be non-Oregon Health Plan,” he said. “Their families have very low income, but they still don’t qualify. You always wonder about money being an issue....We can serve those families, we have a sliding fee scale, but you never know how many people just don’t come through the door because they are worried about cost. Even though we do offer

sliding fee scale, and bill insurance, and all that” (026, 3). However, most mental health providers said that they couldn’t afford to serve clients on a sliding scale except those in severe crisis. One of the mental health consultants explained how funding prevented her rural agency from taking clients on the sliding scale. “I think there is a huge gap in our county, for children who are not on Oregon Health Plan,” she said. “They do take people on a sliding scale, but that is limited to people at high risk. We have enough staff. But we don’t get any money for people that are on sliding scale. We get \$5 for their visit. That’s not enough to cover the expense of seeing them. So unless they are really at risk, we don’t...” (015, 3). Mental health providers sought ways to serve families who were not eligible for the Oregon Health Plan. Three agencies were able to provide services to a limited number of families through the state Oregon Children’s Plan grants, as has been discussed earlier.

In addition to the gaps in services caused by limited geographic coverage, a focus on the large number of crisis cases, and funding restrictions, one additional large problem was identified by both mental health and EI/ECSE personnel. This was related to parents or caregivers who had their own mental health issues and needed services.

Limited Services for Families

About half of the EI/ECSE and mental health providers identified a crucial gap in services for parents. The first was related to funding. The Oregon Health Plan did not provide enough adult behavioral services; parents’ only other option was to seek private treatment if they had adequate insurance. One EI/ECSE provider estimated that about

3%-5% of her families would benefit from accessing mental health, but she identified the lack of services for adults as a serious limitation for children as well. “I think as far as referrals for families,” she explained, “there just aren’t options for places to refer them to, if it is the parent who has the mental health issue....So the 3-5% would be families where it is really the child who needs the support. I mean the family needs it, but the insurance is from the child. And I would say that is a weakness of the system. A number of children that we serve, their parents could really benefit from their own mental health services, but the Oregon Health Plan is so limited on how many adults they enroll, that affects kids as well” (005, 12).

Agencies stated that they could provide limited services for parents without insurance. One mental health provider explained that it was mostly the case that the child had the eligibility. “We can and we do provide some amount of individual therapy to the parents if they have their own Oregon Health Plan,” she explained. “If not, we will try to work with it as family therapy without the client present.... it’s not difficult to do therapy with parents alone. We do it. We work it out with our charts, explaining that stabilizing the parent is what’s needed to provide the best intervention for the child’s functioning. But we can’t provide medication or psychiatric services if they don’t have Oregon Health Plan. And for some people, that would be an important adjunct they can’t get” (029, 4).

Another issue that was brought up by both EI/ECSE and mental health providers was the difficulty of getting some families to accept mental health services. An EI/ECSE provider in a large agency explained thoughtfully, “It’s kind of a double-edged sword, I think. Oftentimes families that have kiddos that are really struggling, the family itself is

struggling. So trying to get them into services, even our own services, is a task, just because of where they are” (004, 3). A mental health provider discussed the wide variety of issues that got in the way of parents bringing their children to therapy. “Meaningfully engaging all of the families doesn’t happen as much as we’d like,” he said.

“Transportation is often a challenge. Getting parents to commit to bringing their kid in, and wait while their kid’s being seen, that can be a challenge. I don’t mean just car and gas. They may not have appropriate car seats, they may not be able to take time off from their job when they are the sole income. It’s all those kinds of things” (017, 8).

A certain proportion of the families that EI/ECSE providers worked with were resistant to services. One provider ascribed a lot of resistance in using mental health services to the stigma of being seen as mentally ill. She believed that normalizing around the difficulties of parenting would be productive in getting parents to seek help. “It’s hard to admit that you don’t know what you are doing, or that you need help,” she said. “That really tends to be the stigma and the perception that parents have, is that they are having difficulty with parenting. So I think more marketing around, ‘There’re a lot of difficulties around parenting’ would be helpful. That tends to be really difficult” (023, 9)

The urgency related to participation of families was found in interviews with several mental health providers, who expressed frustration when parents did not participate in their child’s therapy. “I think attachment and bonding is pretty paramount with young children,” said one. “When their parents aren’t invested, that makes it really hard to make headway if they are not willing to look at their own issues, or the environment, or the context in which they are raising their children....All of the research

and all of the evidence suggests that active, interactive, present parents make the child healthier in the long run. Those pieces, to me, are very important” (017, 10). One of the mental health providers believed that there needed to be work at the systems level to improve parents’ participation in therapy. “Obviously we work with some parents that are mandated by child welfare or the court systems to participate in either alcohol and drug treatment which we provide here, parent training which we provide here, or family counseling. We do those things,” he argued, “but sometimes for the non-mandated, the voluntary people, they may be difficult to engage. And it just seems easier for them to say, ‘Fix my kid and then send them back.’ ...I think it’s more than just the treatment end. The whole system has to look at that, the child welfare system, juvenile department, mental health. How do we approach parents, how do we do it so we can achieve some better successes there? It’s a constant issue” (026, 4).

Discussion of Issues

In this chapter, a large number of issues were identified that prevented EI/ECSE agencies from believing that their families were receiving adequate mental health services. Many of the issues were related to how mental health agencies made decisions to use their limited public funding. These included triaging services to serve the clients in highest need, which forced a focus on serious mental health problems versus more preventive ongoing work, providing the bulk of services in the most populated geographical area in rural counties, and serving only families on OHP. Another barrier was the difficulty in hiring and retaining qualified personnel, which in some parts of

Oregon severely limited the capacity of agencies to serve children. Other impeding issues were endemic to the population of families that needed mental health services, including the lack of time and monetary resources, or resistance to services among some parents because of their own psychological issues.

In returning to the recommendations made by EI/ECSE providers, it is apparent that many of them focused on developing strategies that EI/ECSE agencies could accomplish within their own resources. Training for providers on working with families, increasing the capacity of parents to support social-emotional development in their children, learning to identify and work with serious mental health problems in children, and hiring social workers are all strategies that agencies can pursue independently of working with mental health agencies. It is possible that EI/ECSE agencies focused on the kinds of strategies their own agencies could accomplish partly because of the current difficulty of getting mental health services for all but the most seriously affected children.

The need for staff to develop expertise in mental health was echoed by a mental health provider who was building early childhood services for her agency. She felt that all disciplines that work with early childhood should have fundamental training in early childhood mental health and in support for families.

There is such overlap, you know, because for young children, a healthy, stimulating environment is usually what promotes the whole individual, be it physical health, be it mental health, or be it school preparedness, readiness to learn. They are all dependent on that stable, healthy, stimulating environment. So we are all trying to promote that....My personal belief is that all the disciplines serving childhood should have the same kind of training in what are the needs of children, what promotes healthy play, what promotes best developmental growth (006, 14-15).

This provider believed that all early childhood workers had the same goal: to help support a healthy, nurturing environment for the child. The fact that many mental health programs were developing early childhood services is an indication of their capacity to become partners because they are invested in working on the same issues of concern to EI/ECSE.

It is apparent that many EI/ECSE providers believed that the problems inherent in serving their children and families with mental health issues will not improve until a closer partnership with mental health is developed. This will happen only through working partnerships in which mental health and EI/ECSE understand each other's needs and share resources.

An EI/ECSE provider commented about the way each agency was currently focused on its own clientele and way of providing services. "We definitely need much more comprehensive services for little kids," he said. "And I would really like to see some more collaboration between agencies, rather than people sort of sitting off in their own turf, doing their own work.... It would be nice to share all those resources, rather than people serving their own little corner of the world" (002, 19). This was echoed by an early childhood mental health provider who had a good collaborative partnership with the EI/ECSE agency in her county. She expressed the belief that there needed to be better communication and flexibility among partners to support families more effectively.

When we are working with a family where part of the issue is chronic chaos and stress, I think that is a really good example when all of us are saying, we might be able to impact this to some degree, but my little piece isn't quite enough. How do we coordinate? And it might be that sometimes families who have EI/ECSE in their family, well that's ok, because it's school. And school's ok, but they don't want mental health involved in their lives. Or it could be, well I like the home

visitor from public health, and they are helping keep my child healthy, but there is nothing wrong with my child. He doesn't need specialists, he isn't dumb. For whatever reason, parents are interested in, or feel supported by one program, but don't like the idea of the other program, or we all know that the family needs so much, and we are all sort of, to some degree, separately trying to provide our little piece of the pie to help support the family (006, 14).

Recommending that EI/ECSE agencies seek better relationships with their county mental health providers is not likely in and of itself to lead to better early childhood services from mental health, particularly in counties that have serious problems with limited funding and personnel. However, closer collaboration would certainly increase understanding of what each community partner could contribute to improve services for families and children. The solution to EI/ECSE providers' desire for regular mental health consultation will likely not be solved by expecting the public mental health programs to provide this service, but more likely through creative, cooperative solutions such as cross training, as suggested earlier by a mental health provider. There is the potential, for example, for EI/ECSE agencies to train mental health providers in their counties in early childhood development and strategies for working with young children. There is also the possibility for mental health to provide training to EI/ECSE staff in improving their therapeutic relationships with parents and in recognizing mental illness in children and families as part of making appropriate referrals. These kinds of creative solutions will only evolve through close collaborative working relationships.

CHAPTER VI

IN-DEPTH CASE STUDY OF AN AGENCY WITH MENTAL HEALTH CONSULTATION

Introduction

In the state-wide study, the most commonly expressed need that appeared in recommendations from EI/ECSE coordinators was for their staff to have regular access to mental health consultation through someone working with them in their agencies. Many questions arose while speaking with the EI/ECSE providers that were related to this need. Why don't more agencies have this partnership? What stands in the way? Would having mental health as a regular partner encourage agencies to serve different kinds of children? How would work with a mental health consultant affect the relationship of staff with parents and children? Are there philosophical differences that drive agencies to seek a mental health perspective in their work? An opportunity to have more lengthy conversations with EI/ECSE providers through the in-depth study over a period of five months began to answer some of these questions.

The agency in this in-depth study is unique its pursuit to hire a mental health consultant with its own funds. The history of its interest in developing a mental health perspective, how it worked within its community partnerships to support the development of mental health services, and the ways that mental health consultation were used in the

agency by staff will form the basis of this chapter. This study will be treated as a long vignette without intermingling analysis. A discussion of the issues raised by studying this agency in depth will be provided at the end of the chapter.

How Mental Health Consultation Came to the Agency

One medium-sized EI/ECSE agency in a largely rural county in Oregon is innovative in bringing mental health consultation to its county. The vision of its staff goes beyond services for its own agency. It has participated for years with other child-serving agencies in the community in actively collaborating to provide services for children and families, understanding that no one agency can begin to meet the needs of the large number of families living in poverty in their county. In the words of one provider, “How could we do this if we didn’t sit down with everybody?” (106)

For the past six or seven years, the agency has been seeking training in how to work with families in a way that would improve their understanding of family dynamics and how these affect children’s development. Individual and group experiences of staff members have provided impetus to build their skills in working with a mental health perspective. Recently they have hired a mental health consultant who is based in their agency.

The agency supervisor explained that the size and resources of her agency are factors in the way it has developed its own internal expertise in behavior and mental health. “We don’t have a behavior team. The difference for us is the size of our program compared to larger counties. They have an economy of scale where they can identify

people as specialists. Our program is much smaller, and pretty much our EI specialists have to do it all....we have trained staff all along, our generalist people, in understanding mental health needs and understanding challenging behaviors.” (101-3, 3)

The supervisor described her experience attending a lecture by Marie Claire Heffron several years ago. Heffron, whose work with colleagues was discussed in Chapter 2 of this study, is an advocate for the integration of infant/child mental health perspectives with work in EI/ECSE. She argues that EI/ECSE agencies must focus on relationships, and develop collaborative and therapeutic relationships with parents (Weston, Ivins, Heffron, & Sweet, 1997). The lecture stimulated a realization among the staff that their work up until this time had been child-focused, and much less on how staff could impact the parent-child relationship through a relationship with the family. As an agency of providers who shared a common interest, they were able to eventually hire their own mental health consultant. “We started asking what we needed to do, philosophically and training-wise, to move people that way,” explained the agency’s supervisor. “And it’s been a pretty gradual evolution, starting with some awareness-level training, and then moving into more philosophical discussion, and then getting into more practical strategy-based training, and culminating now with having a consultant with us” (101-11-04, 1).

At the same time, the agency was seeing a larger number of children with behavior problems and felt they needed to find new ways of working with children and with families. An EI/ECSE specialist described this rising problem. “It seems like the last 5-6 years we have pushed understanding behavior and social-emotional health. We were

getting really bombarded by behavior problems it seems like about 6 years ago. So we needed to learn more about what is going on at home, and how can we work differently with families and children, or see this behavior differently and understand what is going on” (105, 5). The staff was interested in developing a relationship-based focus to work with families, but they felt they had little training from their personnel preparation. As one EI/ECSE specialist described the agency, “We are very relationship-based in wanting to understand the components of the health of the family and how that affects the child and their behavior, and how they relate to others.” (105, 5)

The EI staff/classroom supervisor has been a particularly influential person in steering the agency toward pursuing more strategy-based training in a mental health perspective. On the advice of another staff member who had attended a training by Janet Dean, a mental health therapist who worked closely with child protective services in Colorado, she wrote a grant to bring the therapist to lecture in their region and provide supervision training to her agency. Dean’s presentations centered on how she effectively used videotape on home visits with families who were threatened with removal of their children for neglect or abuse. She introduced the audience to new mental health concepts such as the need for awareness of their own feelings on home visits, and how to patiently and subtly change thinking patterns in the very difficult people they were working with.

The staff/classroom supervisor spoke about her motivation. “A co-worker and I spoke together about how powerful that is to be able to really be with people in their home and listen to what they have to say, and not be afraid to hear it or to deal with it. And, you know, one thing led to another. Well, why are we afraid to hear it and deal with

it? Well, we don't know anything about it. We're just trained to be with kids. It doesn't extend beyond that" (103, 1).

She was particularly interested in bringing Dean's case coordination to her agency. "She does this case consultation process where you view the videotape and you sit together," the staff/classroom supervisor explained. "She and the person working with the family sit with the tape or CD and she really takes that person through the process. We really loved that, and we wanted to experience that ourselves." (103, 1). They didn't have enough mental health experience to implement the model themselves, and needed support from a mental health therapist.

In 2003, the agency accepted an invitation to participate in a federal grant through the University of Oregon in which an experienced early childhood therapist was placed as a consultant in their agency for a year and a half. As the staff became comfortable working with the therapist, they set up their own case consultation model around videotapes of work with families on home visits. The mental health consultant had some experience doing case consultation and led them through reflective supervision during the group process. At the end of the grant funding, the agency attempted to hire the mental health therapist, but was unable to offer her full-time support. Instead, she took a job at the local community mental health program as an early childhood therapist.

This proved to be an important addition to the local mental health services because of her experience and interest in working with very young children. She has become the primary outpatient therapist for children birth to five. The EI/ECSE supervisor believes that her move to the mental health agency was of real benefit to their

agency. The supervisor had been working for years to improve services for young children in the mental health system. “One of the things we were trying to impact was how the mental health system viewed the issues of young kids and parent-child relationship issues. And when [the therapist] then moved into that position, that systems-impact has been made (101-1, 6). She further described the great benefit to the early childhood community for such an experienced clinician to join the county mental health agency.

Having someone who really has the skills and the interest in working with a younger population, that’s key. You’ve got to have someone who knows how to do it and wants to do it. When you’ve got a bunch of really busy people who are going in directions that either their interests or their funding or their program structure takes them, then it is going to be organized around those things. When you have someone who has an interest and skills in working with younger kids and in dyads, then that can happen. (101-1, 2)

Issues Around Funding a Mental Health Consultant

The agency was able to hire its own in-house mental health consultant by filling an EI specialist position with a person who had experience in infant mental health work. She had a Marriage and Family Therapist degree and had worked for several years with high risk families. In her new position at the EI/ECSE agency, her caseload consisted primarily of home visiting with families who had children with social-emotional delays and needs.

The agency supported the other half of her position through two funding sources. She became a mental health consultant for Head Start. The agency’s region had also received one of the Oregon Children’s Plan state grants for mental health consultation.

Through this grant, she provided mental health consultation to the entire community for agencies that served families with young children.

The two mental health consultation jobs were very time consuming, and combined with her half-time EI Specialist caseload, gave the specialist little time to consult on mental health issues with the EI/ECSE agency. In the Fall of 2007, the supervisor was able to re-negotiate the mental health specialist's position and make her a full-time consultant. In the past year, she has provided more consistent consultation to her own agency.

The EI/ECSE supervisor has repeatedly expressed frustration over the difficulty of funding a mental health consultant in her agency. She attributes the difficulty to several factors. She has investigated what kinds of credentials are needed in order to be reimbursed for treatment in the education-based mental health funding system. She discovered that under Oregon's Medicaid billing laws and education-based Medicaid, the only professional who can bill for providing services is an L.C.S.W. Even though her mental health consultant has an infant mental health background, experience as a marriage, family and child counselor, and is licensed as a professional counselor in Oregon, she cannot bill for any of her services under school-based Medicaid. She is among a small and highly specialized group of early childhood therapists, but she cannot get reimbursement for treatment services.

The supervisor feels that these credentialing restrictions do not support mental health consultation in the birth to five age range. The services aren't realistically reimbursable because there aren't very many qualified people who are currently trained

and experienced in working with this young age range. She argued that reimbursement for this kind of work shouldn't be constrained to a few credentials. "I wish it could be, in many different fields, more open to what are the competencies, what are the skill sets that you need to be effective in this work, and train with that in mind....Whether they can do the work that I want them to do has more to do with their experiences, than with the particular degree that they chose" (101-1, 1).

Although she has been able to fund the consultant through her own program resources, the supervisor believes that most programs won't be able to provide those services until mental health consultants become realistically reimbursable. "I don't think there is anything right now preventing us from using education dollars to provide a needed service on the IFSP that might say mental health consultation, but we also have to have enough resources. For most programs, that is probably an added service. To provide it they need to have dollars beyond what they are seeing as the basics that must be provided. There need to be additional resources" (101-3, 5).

The supervisor has found ways of creatively funding the position through grants and mental health consultation to community early childhood programs. This Fall, the mental health consultant added a contract with Early Head Start to her consultation work. The supervisor describes the difficulty in juggling funding to maintain a service that her agency needs. "I just worry about the whole up and down nature of things. Now that the mental health consultant has let go of that other hat, of being an EI specialist, I see people here accessing her a whole lot more, which is great. It is very exciting. I won't have an issue from my perspective of justifying continuing to have her in that role out of our

special ed funding, as long as we have enough of it to go around. I don't feel like there has to be a special pot of money that says this is to be used for mental health consultation. It's just a matter of the overall resource shortage. So that would be one strategy, that we need to be sure that services are adequately funded all the way around (101-4, 3).

Collaborative Work in the Community to Build Children's Mental Health Services

The agency supervisor and mental health consultant have served on community mental health committees as part of the state system change in mental health occasioned by the state Children's Change Initiative (Allen, Friesen, Koontz, & Koroloff, 2006). The EI/ECSE supervisor has been a member of the regional education mental health task force focused on linking school systems with mental health service providers. Their goals included identifying gaps in community services and looking at funding and services in a more flexible and creative way to address them. The group tended to focus on the school-age range, and the supervisor felt her role to be an advocate for early childhood services. She believed that one of the greatest benefits of collaborative committee work was that the partners came to understand the realities each are working under. For example, she pointed out that mental health is oftentimes blamed by other agencies for not doing everything it can to work collaboratively. Working on cross-disciplinary committees allowed her to see that this misperception has been caused over the years by their response to budget cuts and high caseloads.

The supervisor discussed the extra effort that agencies need to expend in order to work in close collaboration. It is time consuming, and they often do not receive any reimbursement for it. “When you have a system that gets designed around how many units of service you provide, all of the up-front stuff that you have to do to get to that place, where you have the kind of trust where the family is going to come back and they are going to stay with it, and where other people, like child protective services, knows what you do, and mental health knows what you do, and you have credibility within the community that you know what you are talking about, all those things take a lot of time” (101-3, 10). She felt that this kind of work through community collaboration was one of the most important avenues to improve services.

The mental health consultant partnered with her supervisor in committee work. She participated in the mental health Care Coordinating Council that was formed in their county for community-level planning and coordination. Her consultation work through the Oregon Children’s Plan grant also gave her a unique opportunity to build collaborative relationships with other community agencies. She developed close partnerships with mental health, child protective services, the domestic violence shelter, and Head Start.

The Work of Mental Health Consultation

In her consulting work, the mental health consultant has found that Head Start has a very different focus than her own agency. Head Start consultation has focused on recommendations to classroom teachers on how to support children with behavioral

difficulties. Her work consisted of coaching, teaching, and training related to children in the classroom setting. She found fewer opportunities to talk with teachers concerning their feelings about having challenging children in the classroom. She found that Head Start, unlike her own agency, did not emphasize self-reflection in working with challenging children.

In contrast, the EI/ECSE agency required a style of reflective supervision to build staff's capacity to work with difficult families. The EI/ECSE staff were interested in being trained in a mental health perspective that increased their awareness of their own emotions brought up as they worked with families, and how to maintain professional boundaries. Her expertise in the EI/ECSE agency was described by the supervisor as more mental health, and less behavioral-focused. Her work is "more about understanding the dynamics of relationships. More about clinical perspective on what it looks like for a parent to have depression or substance abuse issues, and how that, then, affects the relationship....I think what she brings that a behavioral specialist in some of the other models that I have seen across the state might not bring, is the mental health perspective and training in more of a psychodynamic understanding of things" (101-3, 3).

In their interviews, staff in the EI/ECSE agency consistently talked about learning to become more self-aware and working with their own feelings. The EI staff/classroom acknowledged that she has routinely incorporated this awareness of how events trigger "deeper inner things that are happening within myself or have happened within myself. These can be touched upon by something that somebody says, the climate of what's happening in the home visit" (103, 3). The difficult emotions demand self

reflection, and help from someone such as a mental health specialist who understands how to work them through. She described the process in this way: “I need to be really able to self-reflect. I need to be able to get in touch with myself when I am feeling something, and stop it right then and there. Stand back and observe. Learn some techniques towards keeping myself neutral in a situation” (103, 3).

An EI/ECSE specialist described a situation in which she was supported in processing these kinds of emotions after a difficult encounter with a parent who had become angry with her. She has learned that if emotional triggers are not brought to consciousness, emotions can make staff feel incompetent. By seeking support from the mental health consultant soon after the event, she was helped to maintain her professional behavior. “The consultant helped me be able to self reflect and not take things personally with that family. Understand who these kids were living with, with this mom. I was able to call the family, and to re-screen the kids later on, and follow them in their development. This family now has one child who has qualified for services. At first I was scared to death of this mom, but working with [the mental health consultant] has made me aware of not taking things personally, knowing what the mom’s needs were” (105,1).

Learning to recognize and understand the needs of parents and other caregivers has been nurtured by the mental health consultant in many of the staff. This theme appeared in conversations with both direct service and eligibility specialists. For example, an eligibility specialist contrasted her tendency to become defensive of children with the need to take their parents’ perspective. “I can sometimes be a little harsh when I see a family or a parent who is so self-absorbed and so oblivious to what their child

obviously needs. And then that mental health specialist can come back to me and say, 'but wait, look at where the mom is, and what she needs.' And I realize it would be very helpful to pay attention to that" (104, 2-3).

The mental health consultant now has a weekly time slot in which she is in the office and available for staff to drop by her office. "People drop in. I had a drop-in this morning. As soon as I got here, somebody stopped by and chatted with me for a little while about a child, asking for an observation, and discussing the next steps in terms of who we should be involving, child welfare or mental health. It really does happen very spontaneously. I think that is one of the benefits of me being here more, is that I can meet those needs when they arise, not wait a week or two when I can get to them because of my schedule" (102-2, 6). She is asked to consult on a wide variety of issues. In one case she has acted as a buffer for the EI specialist with a mother who was emotionally volatile and difficult to work with. In another case, she became an advocate for a child who was medicated for ADHD. She provided the physician with information about what she was seeing in the classroom and how she believed the child was suffering more from anxiety and less from ADHD issues. She also supports highly anxious families during their child's transition to kindergarten. She is able to attend transition meetings to explain the mental health perspective to the school.

Some of the more experienced staff used the mental health specialist as "more of a sounding board kind of experience" (103, 6). They sought her out when she was in the office when issues came up in home visits, or they needed problem solving related to mental health, such as maternal depression, problems with the relationship, and anxiety

in the child. "Pretty much, just hey, I've got something that came up. Can I tell you about it? We try to give a little background about families. Sometimes she has questions in mind that she will ask. She will put out some ideas to think about. Sometimes she has some specific suggestions, like 'This sounds like a parent who has --.' That can be helpful" (103, 6). The EI staff/classroom supervisor had integrated self-reflection into her work through years of experience, and seeks out other staff as a way of confirming her own decision-making. "Nowadays, for me it is more of, maybe it would be good to run this by someone and see if what I think is happening might be the same as what somebody else thinks is happening, before I start trying to figure out how I want to go about working with this family" (103, 3). She relies on the teamwork in the agency, and draws on the insights even of staff who don't have a mental health orientation. "You know, we've been in the field for a long time, we have a lot to share, so there is a lot of benefit from that too, for us" (103, 3).

Staff who worked more closely with the mental health specialist invited her to accompany them on home visits. They reflected together afterwards, sometimes with videotaped records. The use of videotape allows the consultant and staff to jointly identify moments they can use to build a trusting relationship with the family. The EI/ECSE specialist told of one incident in which the consultant gave her specific direction. "She was reflecting with me that the mom was really able to light up when her child came to her. She encouraged me to make this point to the parent by telling her, 'Boy you are really excited and happy that your child is coming to you. Look how your son seeks you out, how that makes him feel good.' And that makes them feel good about

their parenting skills when maybe they don't even see themselves as being good parents" (105, 4).

The staff often need support in identifying where to make headway with difficult parents who seemed immovable in their habits and capacities. The EI/ECSE specialist works with families in a part of the county that has the highest generational poverty. The agency serves a very high rate of families who are eligible for Medicaid, estimated at a rate of 70%. In the poorest part of the county, the rate is 95% among families served (101-1, 5). The EI/ECSE specialist identified 13 out of her caseload of 18 as needing social-emotional support. Half of her children had been through child protective services.

The EI/ECSE specialist had five children on her caseload who were affected by methamphetamine exposure during their mothers' pregnancy. She provided several examples of how the expertise of EI/ECSE staff, with the help of reflective work, can distinguish the effects of neurological damage from how it manifests in extreme behavior problems.

This was a foster child who was attacking his siblings, and he was only 2 years old. He was attacking his brother and just leaving gouges on his face. He had lots of bruising all over his body because he was jumping from counters, doing really dangerous things. During the evaluation, I started having him jump up and down, and he just loved it. And then we were roughhousing, and then pretty soon he fell asleep. So I talked back and forth with the consultant about how he calmed down, and maybe when he is jumping off the counters what he was seeking is that proprioceptive input. So this child has turned into our miracle kid, because that is exactly what he needed. His behavior was showing us that he really needed that input. His foster mother said this was the first time she had seen him that calm. We taught the mom how to help him, and those things made huge changes in their lives. Now, he's 3, and he knows what he needs. Rather than striking out at his siblings, when he gets mad, he will stand and scream and jump up and down. He'll be done with it and once someone acknowledges him, then he'll move on (105, 15).

In home visiting, the focus of EI/ECSE work is on helping parents support their children. This starts by building a trusting relationship with parents and often helping parents improve their self-esteem. This is illustrated in a story told by the EI/ECSE specialist. She was in a difficult situation in which a mother who had developmental disabilities seemed to pay no attention to the needs of her child. “The way that I started my relationship with her two years ago was to just sit and listen to her, because she wasn’t going to listen to me talk about her son or go into a decision regarding her son. She was focused on her fingernails, or her car” (105, 4). The mental health specialist advised her to find ways to praise the parent. “Very small steps of praising her in what she can do. Even if it is folding laundry, feeding the child, which sounds very basic. Making a point to support her efforts in doing that, to make her feel good about her parenting skills” (105, 4).

She described many families as being resistant to having home visitors. She has invited the mental health specialist to accompany her on the home visits and observe families, to “direct me as to different ways to interact with the parent, or being open to the parent in a different way, so that the parent can see the child’s needs.” (105, 5). When videotaping occurs, the mental health specialist is behind the camera, acting as an observer. “She is usually quiet and gets all the good stuff on video” (105, 5).

The Boundaries of Mental Health Work in EI/ECSE

Staff in the EI/ECSE agency believed that the mental health consultant should function as part of a transdisciplinary team in which staff with specific expertise train

each other. Through this process, staff develop “rudimentary or foundation ability” (103) to work with children with a variety of special needs. It allows one staff member to be the primary case manager and to build a trusting relationship with the family. The expertise of the mental health specialist supports staff in developing the comfort level they need to work with families. One staff member compared this to the traditional way staff develop skills through training from related specialists. “I think the primary thing is to be comfortable sitting in homes where some unfamiliar or disturbing kinds of things might come up. I feel like it is important to have the mental health background, that person there, as someone you can consult with, just like we do with the occupational therapist, physical therapist, or speech therapist...It is a really powerful way of spreading, you know cutting up one loaf of bread and making it enough for everybody, to have this key person who can share her expertise and filter it out through all of us” (103, 4).

When working as a team with the mental health consultant, the agency has continued to do group case consultation on a monthly basis until recently, when high caseloads have prevented them from meeting regularly. Case consultations have been planned when one or two staff members volunteer to present a case. All of the specialists and teachers are invited to participate. A videotape of the family is shown, or the staff member and the mental health consultant dialog about the case. The EI/ECSE specialist described her experience in using the group consultation.

There was family that had massive garbage all over their house. You could barely sit down in there. So we videotaped a home visit and shared it with the staff, just to get feedback from everybody as to what would they do? The staff suggestions were very helpful. They thought garbage must indicate something that is going on in the home. They brought up different factors, like finances, depression, stresses,

and not looking at this as just garbage, but asking ‘what is going on?’ It was validating to know that working with this stuff takes time (105, 4-5).

Instilling a mental health perspective into an EI/ECSE agency has its boundaries in how far staff with educational expertise can or should use mental health strategies. The supervisor acknowledged that all early childhood programs are faced with families who have mental health issues. “And I also think that it is a reality that EI specialists get asked all the time in their work to do things that are probably within the scope of what most people would see as social work practice or counseling... They are in there, in the moment with families who are revealing things to them that deserve a response. And so they do respond, but they have to separate their response from, is what I am providing an empathic ear in support of this relationships and hearing your concerns, or is it counseling or therapy?” (101-3, 15). She believes that having a mental health consultant on the staff is an important way to increase skill in supportive dialog with parents, in allowing parents to tell their stories, and being able to hear what they need to talk about. She acknowledged that it is important to recognize that each EI/ECSE staff member will have their own comfort zone, and for each person to identify where that zone is in working with families.

I understand from a philosophical standpoint why people would separate mental health and education, and I certainly understand boundary issues. I think within the reflective practice kinds of things we have done, we have tried to help people identify where that line is....But how comfortable an individual person is with that place of being the empathic ear is where the line is different. I think there is a line that I could draw that says you shouldn’t be doing these kinds of counseling things. But there are individual people who would draw the line further away than I would, because of their own comfort level. And that is part of how we have tried to use [the mental health consultants], is in supporting people’s expanding knowledge base and comfort level in just being in that place with somebody who

is telling you something. Telling you about the story of the child's birth and how that has impacted the family. Or what it means to live with a child with a disability. (101-3, 15)

EI/ECSE staff need strategies that support changes in the parent-child relationship. They also need to recognize when their own skills are surpassed and symptoms of mental health problems indicate that the parent or child needs to be referred. They need support from mental health consultation when they continue to work in the home with families who have mental illness.

You have to be able to observe and know how you can support them in the moment and then move them along to, ok you need more than I can provide here. You may need medication, you may need ongoing treatment. And those are the things we can't do as EI specialists. But certainly we can provide the kind of comfort in a relationship that allows somebody to share something that needs to be said in order for them to take the next step. And as an EI specialist, you have to be open to hearing it, create the trust level within a relationship where it can be said....you do have to deal with it being part of the dynamics of the home that you are in, the family that you are dealing with, the relationship that exists between that parent and that child. (101-3, 15)

Eligibility for Children with Mental Health Needs

One of the areas where the agency has used the mental health perspective is in screening children for eligibility. The mental health specialist explained how her training adds to the educational expertise of the EI/ECSE staff, particularly during children's assessment. "So often, young children's lives and the things they are experiencing in the home impact their development....So seeing a child come in here with certain kinds of delays - cognitive delays, speech delays, social-emotional kinds of things, having someone looking at that child through the mental health perspective versus the special education assessment, I think, adds to a better picture of that child, where they're at and

what their needs are.” (102-1, 1). She sees herself as taking a more holistic point of view, which is different from the more narrow focus on educational development that EI/ECSE agencies must take to remain within eligibility standards. In assessing children, she argued, “We can’t just look at these skills over here, and that skill set there, you know, without looking at where they are coming from, and what their environment is like, what their relationships are like, and what kind of support they get or don’t get in the family” (102-1, 2). She compared the tendency during educational assessments toward compartmentalizing children’s skills into domains of development with a medical model of treating symptoms separately from the whole person. “I think in a way, without looking at the relationships in families, we are doing the same thing. We are not looking at the whole. We are looking at how many words does he say, is he putting two words together? We’re not looking at the fact that these language skills are developed through relationships. And what is impeding this parent-child relationship, and how can we support that?” (102-1, 2-3)

The agency has been developing over the past five years an expertise and interest in serving children with significant mental health needs. The EI/ECSE supervisor believes that her agency may lean more towards identification of children with social-emotional delays than many other agencies in the state. “My perspective is that it may be coming from risk, but if it’s presenting as a delay, it doesn’t really matter if it is environmental or neurological or whatever else. You are dealing with what is in front of you....So unless you can really say from a treatment perspective that mental health is

going to meet this need, and they don't really need special education, that's the decider for me" (101-3, 19).

When children qualify for both systems, they are served by both mental health and special education at the same time. The supervisor and mental health consultant reported that they were currently serving a child diagnosed with reactive attachment disorder. "If it could be reasonably expected that the child's issues could be dealt with in therapy alone and they didn't need the additional support from special education services, then maybe you would just go with mental health. But it seemed like the course of treatment, in my understanding of reactive attachment disorder, is pretty long-term, and the additional supports that would be available from our setting would be beneficial" (101-4, 2).

The agency has recently added mental health consultation as a related service on children's IFSPs. The mental health consultant is currently providing this service through the IFSP contract for 12 children, and consults informally on many more. Consultation is provided at 2-6 hours annually, and may be provided to the family, the child, or the EI specialist. "That might mean that I go and do an observation of the child in preschool, and then consult with the preschool staff on that. That might mean I consult with the EI specialist with the child, and then I'm working with the family to try to get continuity between school and home if we are working on a behavior plan" (102-2, 7).

The eligibility process used by the agency for making children who have social-emotional delays eligible has improved over time, and has benefited from having a mental health consultant on the eligibility team when there are concerns about mental

health issues. The supervisor thinks that over the years they have changed how they look at kids with social-emotional problems. “I think we are looking differently at kids than we were before, and might not have included some of those kids before, where it was perhaps perceived that the child’s needs were rooted in a parenting issue” (101-1, 5).

The eligibility specialist confirmed that in the past, when children were developmentally on target in all areas except social-emotional, they were not considered eligible. “It used to be that we would say, ‘No, that’s not our bailiwick. We don’t serve those kinds of kids’ (104, 2). However, she described her agency as building its expertise in determining “what is atypical, what’s delayed, what’s significant, what we have to worry about” (104, 2) in children’s emotional development. She felt that having the mental health specialist on staff has contributed to this change.

The mental health specialist is used primarily in the screening phase of evaluation, particularly when children are referred from child welfare, are in foster placement, or when there are significant concerns about behavior or social-emotional issues. She has helped educate the evaluation team about mental health considerations. The eligibility specialist noted an improvement in her own ability to consider different explanations for children’s behaviors and their ramifications for treatment. She described a case in which she attributed a child’s unusual mouthing behavior to developmental delay, but heard a different explanation from the mental health specialist. “My glasses said this kid is so behind and so delayed, he may be three, but he is developmentally much younger. He *should* be mouthing things. That fits in developmentally. She was looking at him mouthing because he was restricted food growing up. We just kind of

looked at it with two different viewpoints. And it's fascinating to have those conversations" (104, 3).

The mental health consultant also educated the evaluation team in her view of children's development within the context of their family relationships, and that work with the family must occur through relationships. "It's about developing relationships with the family, with the child, and enhancing those relationships between the parent and child. I'm a little biased, but I think that supercedes everything else. And if we don't look at that piece, I think we are doing a disservice to our families and their children" (102-1, 2). The eligibility specialist described several instances in which she has learned from the mental health consultant to look more carefully at family interaction. "There are kids who can truly be identified with ADHD before age five, I believe. But there are kids who do present as really hyperactive, but the mental health consultant has helped families see that what is driving it is something different. It could be anxiety....I am so busy, focused on the kid....The mental health consultant will say, 'Well, did you notice that she never once turned to mom and said, look what I did?' Some of the really blatant stuff you will catch, like when a parent can't see anything positive in the child, and doesn't notice what they are doing or criticizes what they do, or takes the object out of their hands and does it for them and says they can do a better job. All of those things are interesting to watch, but I never thought to watch to see if a child would look to a parent. A baby, yes, but not a child, looking to a parent for endorsement that they were doing the right thing, or that they did a good job. I'm so busy watching the kid I don't watch the parent. So she is good at helping you see that whole picture" (104, 7).

The EI/ECSE supervisor believes that programs can't rely solely on standardized tests to determine eligibility for children who have social-emotional concerns. "The standardized tools that most everyone is using are aimed at pro-social kinds of skills and not relationship disturbances. That's not really a part of the tools that are out there" (101-1, 4). She believes that mental health experience on the team is needed to provide clinical judgment in some cases. Although the agency has been reluctant in the past to use clinical judgment, they have felt more confident in using it to qualify children since the mental health specialist has been part of the eligibility team. The eligibility specialist reported that they have used clinical judgment recently on two children over age three. The children received their eligibility through social-emotional delay with a statement written by the mental health specialist about their history and current behaviors.

This EI/ECSE agency, similar to the rest of the state, rarely uses the ED label on children age three to five. The EI/ECSE supervisor explained that when children are very young, it is difficult to determine that emotional disturbance is clearly what is occurring. In most cases the child has other delays and can be qualified under developmental delay. "It's not very often that you can say that's clearly what's going on, and it is really clear. Most often those kids will present with delays in more than one area, and we will call it developmental delay and bring in mental health consultation if we need to" (101-3, 20).

The mental health consultant has preferred strategies for gathering information on children and families during the evaluation process. She believes that it is difficult to observe relationship-related issues between parents and children in an office setting. Instead, she will take information over the telephone, and may do an observation in the

home or childcare. “I try to get the information ahead of time and then in the screening I will be looking at the attachment -- it’s hard to look at attachment unless we activate it by having the parent leave, but we can see some anxiety or other things in there” (102-1, 5). She argues that the evaluation process needs to be improved. She does not think enough background information is gathered on families, and that better information will be obtained by observing children in their natural environments such as home or childcare. Her agency does not have the resources to do evaluations this way unless there is a red flag for emotional problems. She compared the EI/ECSE evaluations with mental health evaluations that she has done in the past. “As a comparison, when I was doing infant mental health work, the evaluation process took over several home visits. You have to develop a relationship with someone before you start asking some kinds of questions. And it would take me maybe four visits (depending on the family and how open, and how far you could get with that) before you really could gather all the information. And then it is ongoing” (102-1, 9). She found that being asked to offer a professional opinion on the little information obtained in an EI/ECSE evaluation was challenging for someone who has been trained in mental health work.

Partnering with Community Mental Health

The county mental health agency is currently the sole provider for very young children in the local area, according to EI/ECSE staff. The nearest private services for young children are located 40 miles away. The agency has the OHP contract with the state and primarily serves children who are Medicaid-eligible. The state provides a small

amount of money for the agency to offer intensive wraparound services for high-risk children who are not on OHP, in order to lessen their risk of expensive hospitalization or residential treatment. The agency works with other programs to find services for children in less serious need who have no insurance. They participate in collaborative planning on early childhood community councils, and have participants from the early childhood community on their advisory board. The EI/ECSE mental health consultant participates in this capacity.

The EI/ECSE mental health consultant works closely with the early childhood therapist at the county mental health program to get treatment for families in the community. Through the Oregon Children's Plan grant, she became a "linker" or connector to mental health services because she would be the first mental health worker to see children and families in the community. In her position on the EI/ECSE evaluation team, she also participates in decisions about referring children to mental health.

However, the EI/ECSE agency still has serious concerns about children who are qualified to receive services from the local mental health center and are referred. The EI/ECSE staff report that many families who need treatment fail to enter the mental health system. The EI/ECSE supervisor summed up this dilemma in trying to get families into that system. "The families we refer to mental health are the neediest families, who most need the services, and have the hardest time getting there. And if they don't make it, they don't get the services" (101-2, 2). The mental health consultant reported that the mental health system has more clients than it can serve. The restrictions placed on the intake process by the local county mental health agency because of their high caseloads

has proven a barrier for EI/ECSE staff to get families into services. The mental health consultant reported that when families have agreed to try mental health services, and then don't show up for the initial intake appointments, they lose their place in line. The mental health center will make two or three attempts to contact them, and then drop them. She desires more flexibility from mental health because of the effort it takes her to convince families to make the initial appointment. "They don't have the concept it just took me three months to get that family prepared, and something happens and the family falls down. I've actually gone with the family, which can help, or I advocate strongly to the child therapist, 'This family needs a little extra help. Give them a little bit more of a chance, or reopen this and try again' " (102-1, 18). A case manager who acts as an advocate from the community, in this instance the mental health consultant, is sometimes needed to get families into services. The EI/ECSE mental health consultant meets once a month with the early childhood therapist at the community mental health center on cases she has referred so that she can follow the progress of intake and treatment. She knows both systems and can directly advocate for more flexibility. This is an important link to early referral and intervention for high risk young children.

The mental health consultant discussed the reasons why a large proportion of families have trouble entering the mental health system. Families face not only the fear of being stigmatized, but must be able to meet the requirements of finding transportation and being on time to appointments. "I mean, we have our hoops; they have them too. It can be really challenging. We might make referrals to mental health services, but I would say at least 50% of them don't pan out. Families aren't ready to make that step. And a lot

of the families that we work with have transportation issues. They have their own mental health problems that are affecting their children, and for them to take that step to get their kid to mental health services is a huge hurdle” (102-1,).

Another description of what can happen on mental health referrals came from the staff/classroom supervisor. She has been frustrated by the lack of “connecting factors” between the agencies. She pointed out that she spends many months developing trust with the family. She recognizes the difficulty they will face when required to build a new relationship with mental health. “These are people who don’t really feel comfortable developing a relationship. Maybe it’s not that easy for them to leave their home, or let another person in their life....I’ve got this family in a place where they might be ready for some extra help, and yet to bridge that with them, to get them over to this other person to build that trusting relationship, that’s enormous....It’s not so easy for them to just go, ‘OK, I’m ready to work on it. I’ll show up with my card in hand and go through the paper work, and introduction, and hang in there for how many weeks before I finally like the person that I am working with and feel comfortable working with them’ ” (103, 7-8).

The staff/classroom supervisor gave another example of what can happen even if the family receives treatment. She believes that agencies that share an interest in mental health for young children and their families need to collaborate together when a family is being transitioned from one service to the other. “What happened in this case was the therapist and the mom were not melding. And the mom was no-showing, but the therapist wasn’t getting back to me to let me know that. So the family failed the acceptance into the program, the 30-day trial. If I had known, maybe I could have tried to problem solve

with this mom about what was preventing her from showing up, and seeing if we could have gotten this worked out. But I think it is a two-way street. I could have taken the lead, but that therapist could have seen me as a resource and said, ‘What’s going on here? This mom is not responding’ ” (103, 9-10). This child returned to services in the ECSE classroom and had a successful year, but later floundered in kindergarten.

For many of these reasons, the supervisor and mental health consultant would like to be able to offer families treatment through the EI/ECSE agency. In many cases, treatment could be successfully initiated only if it is brought to the family. Yet they have not found a way to fund mental health treatment through their agency.

Future Directions

A large proportion of the mental health consultant’s role has evolved into a behavior specialist and trainer for positive behavior support. The region recently received one of three state grants for a PBS grant, which has continued the Oregon Department of Education (ODE) focus on bringing school-age positive behavior support into the early childhood arena. The mental health specialist and her supervisor have been participating in the ODE-supported PBS pilot program for the last two years, and the new PBS grant is an extension of their interest in expanding behavior support regionally.

The EI/ECSE supervisor feels that PBS has embedded in it a mental health perspective in how it helps teachers support social-emotional development. “I think current behavioral approaches, positive behavioral support, has a lot woven into it that has more of a mental health perspective and looks at supporting social-emotional

development and not just responding and reacting to behavior” (101-4, 4). The mental health consultant expressed a similar opinion that the relationships-building aspects of positive behavior support have a mental health focus. In working with her own agency, where the staff are already skilled in behavior management and setting up structured environments, she has been able to support staff in understanding how challenging behaviors relate to anxiety. “They didn’t realize a lot of the things we were doing were so related to the mental health, social-emotional aspects of children’s development. They do these things all the time” (102-2, 9). She is excited about combining behavior support and mental health. “We are not just responding to the challenging behavior with some kind of consequence. We are looking at the child as a whole and what’s happening, and what do they need to learn, how do we help them, what does the family need and how can we support them? It’s bigger. I see it as combining both of these roles” (102-2, 9). She believes that positive behavior support is as much or more about changing adult behavior as it is about changing children’s behavior, which is comparable to doing therapy with families and children.

Summary

This in-depth study was able to examine the issues in serving children and families with mental health problems in more detail. Five significant issues can be identified from the interviews in the in-depth study, and are summarized in Figure 6. These include the documentation of the philosophy behind building a mental health perspective into the agency, how the staff were supported to increase and support their

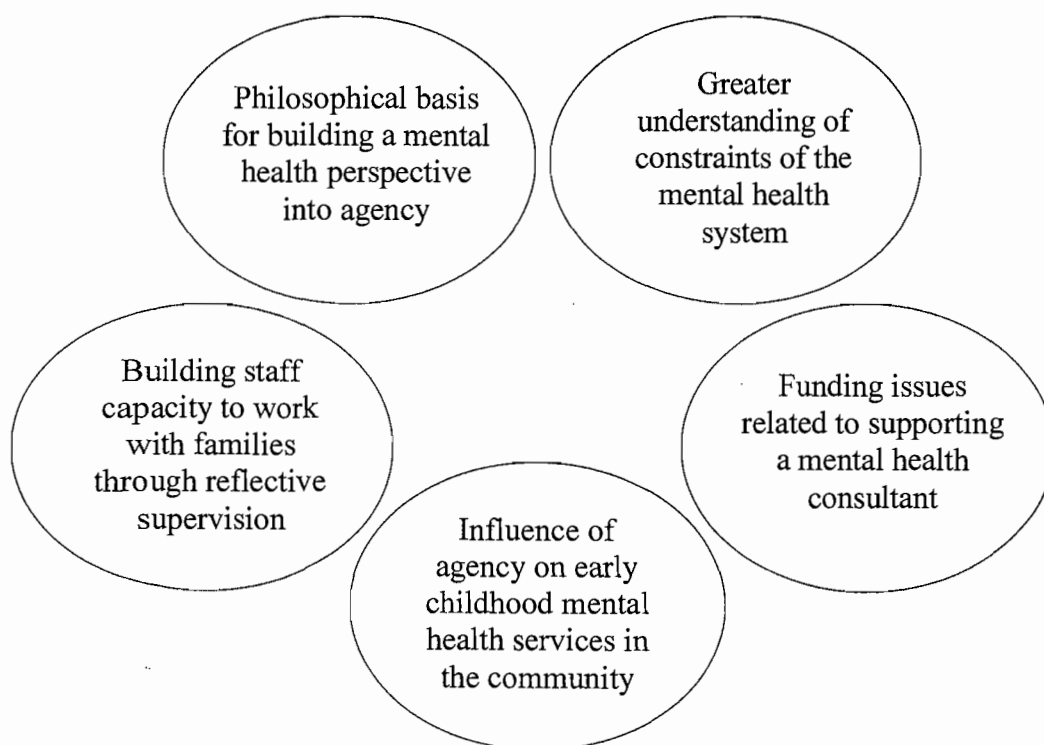


FIGURE 6. Summary of the important issues in the in-depth study.

capacity to build trusting relationships with families, how the agency participated in building community mental health services for young children, the issues related to funding of a mental health consultant, and a greater understanding of the constraints of the mental health system.

The EI/ECSE agency in the in-depth study differed from others in the study in its focus on developing the capacity of staff to work with parents through a process of self-reflection through reflective supervision. Many providers in the state-wide study raised the issue of how often EI/ECSE specialists are faced with difficult relationships with families as part of their work. It appeared to be a motivation for agencies to seek mental

health partnership. To support children's development, they must become comfortable with parents who may intimidate them or present dysfunctional patterns with their children that beg for intervention. This study showed how access to a mental health consultant could build staff confidence and competence in working with families. Providers received emotional support and guidance in how to use self-awareness to regain objectivity after disturbing events. The mental health consultant trained providers about the characteristics of mental illness, and this training helped them learn to understand and predict parents' behavior. A higher comfort level with parents allowed providers to focus on patiently building trusting relationships with parents and supporting their self-esteem.

The kind of language providers in this study used to describe their work with the mental health consultant was strikingly different from participants in the state-wide study. Statements such as, "I need to be really able to self-reflect. I need to be able to get in touch with myself when I am feeling something" (103, 3) and of being aware of "deeper inner things that are happening within myself or have happened within myself. These can be touched upon by something that somebody says, the climate of what's happening in the home visit" (103, 3) are unique in their focus on providers' interior emotions, and working with their own feelings.

The emotional self-awareness and relationship-building work that is seen in this study can be placed philosophically in the continuum of ways EI/ECSE could work with mental health problems that was explored in the literature in Chapter 2. The work of Gilkerson and Stott (2000) identified two perspectives related to supporting parent-child

relationships. One perspective focuses on changing external parent-child interactive behaviors, with the goal of increasing families' competence and understanding of the importance of their own roles in supporting their child's development. The second perspective focuses on the internal or subjective experiences of the child, parent, and provider, while also working on their relationship. The agency in this study was unique among the programs in this study in its focus on the internal, subjective experiences of providers and families as a way to help EI/ECSE providers increase their success in changing parents' external behaviors with their children.

This study was also able to explore the role of mental health consultation in how children are made eligible for services. Conversations with the eligibility specialist and mental health consultant revealed the influence of the mental health perspective in a more holistic understanding of children's development. The agency is not unique in the state in its willingness to make children with primarily social-emotional problems eligible for services and in working with the county mental health agency to refer children with serious problems. The close working relationship with county mental health was able to be examined in more depth in this study, along with the difficulty of referring families who have psychological problems of their own.

Funding of mental health consultation in EI/ECSE is a serious problem. Few agencies have the resources that can be rallied in large metro areas in the way that Multnomah county's early childhood programs could. Agencies must currently rely on their own funding or in patching together creative solutions such as were employed in this program. This study was able to examine in more depth, however, the processes that

communities use to build their mental health services over time. The EI/ECSE agency in this study had an influential role in helping its county mental health agency hire a highly qualified early childhood therapist. Its administrative supervisor and mental health consultant worked with mental health committees on identifying and filling gaps in the mental health system in early childhood services. Through their work in the community they will continue to be active forces in moving the mental health system toward better services for children and families.

CHAPTER VII

IMPLICATIONS OF THE STUDY

EI/ECSE's Role as a Partner for Mental Health Services

It is hoped that this study will contribute to the understanding of the role of EI/ECSE programs in serving the growing population of young children and their families with mental health needs. Several potential points of entry into services were identified at which children with early mental health problems came to the attention of EI/ECSE and other professionals working with young children. In isolated rural communities, Head Start often provided the first opportunity to see children from dysfunctional families. In some small communities, Head Start serves a large proportion of children heading to kindergarten. EI/ECSE consultants are routinely in Head Start to serve children with disabilities. There is a vital partnership between EI/ECSE and Head Start in identifying children with potential mental health disorders. Another point when children can be identified provided by the cross-systems CAPTA federal screening law. This requirement of child welfare agencies to refer young children to EI/ECSE agencies for screening has developed a partnership and concern shared between the two agencies in identifying children who need mental health services.

A third place children can be identified is in the EI/ECSE system itself. In many instances, EI/ECSE agencies are a primary avenue of referral for parents and community preschool teachers who are concerned about children being expelled because of

aggressive behavior. EI/ECSE agencies have developed strong internal strategies to work with behavioral and mental health challenges in their populations. They are often involved in partnerships with community preschools and Head Starts, using their expertise to train teachers and parents to decrease behavior problems. All of these qualities should make EI/ECSE an appealing partner to mental health agencies in identifying and working with children with potential mental health problems as early as possible.

The problems identified in the study related to access to mental health services can form the base of a strong argument for incorporating mental health therapy in EI/ECSE. The stories from staff in Chapter VI about the failure of families to enter mental health services, or to unsuccessfully complete services are evidence for a different kind of service model in which mental health services collaborate with EI/ECSE and other early childhood services. Knitzer (2000) has advocated for providing mental health treatment in non-traditional settings where families and children have their normal activities (i.e., in the classroom or in the home). Incorporating mental health therapy into the trusted relationships already established between EI/ECSE providers and families is an important avenue for increasing mental health services for families.

The partnership between EI/ECSE and mental health holds much potential. As was apparent in the study, however, better mental health services must be built at the community level through collaborative working relationships and open communication. Both early childhood and mental health agencies need to devote resources to learning

how to collaborate and become more flexible in extending their “turf” in the interest of better services for children and families.

The Focus of Concern on Preschool-Age Children

The focus on working with families to support healthy social-emotional development in children with disabilities was a strong theme in the literature discussed in Chapters I and II of this study, but it did not surface at all strongly in the state-wide study of EI/ECSE programs in Oregon. The majority of responses from participants in the state-wide study associated mental health problems with children in the preschool age range. Their descriptions of strategies were related to how teachers work in classroom settings. This occurred across all settings, whether agencies had behavior specialists, or mental health consultants, or were relying on their own EI specialists to work with this problem. Explanations for why EI/ECSE participants’ concerns were focused on preschool age children were not directly explored in this study. However, focus on this age range is consistent with the literature on when adults are particularly concerned about children’s behavior. Campbell (2002) pointed out that the majority of reports about children’s aggressive behavior with peers and problems with disciplining children occur when children are around age three. She also documented that in typical developmental patterns, these problems decrease after age three. When they persist, adults experience increasing concerns that children are not exhibiting normal patterns of development. (Campbell, 2002). This focus of adult concern is consistent with how children came into the EI/ECSE referral process. Typically, EI/ECSE providers suspected some mental

health involvement when they received calls from parents whose children were being expelled from their second or third child care.

Drotar and Sturm (1991) also pointed out that behavior problems in young children with disabilities often have to become quite severe before they are recognized by the family as a problem. For children who are already in EI/ECSE services, this could be a partial explanation for why an association with mental health concerns does not arise until children are older and are interacting with peers in classroom settings.

In a couple of sites in which EI/ECSE providers described their caseloads as including a larger proportion of children with severe mental health disorders, there was an associated urgency for better mental health services. These sites were located in isolated rural counties where mental health services were overburdened by high caseloads and inadequate staffing. EI/ECSE providers focused their recommendations on ways their agencies could provide better support for families. This indicated an understanding on the part of EI/ECSE providers that family-focused work had the potential for lessening the severity of problems in family functioning that Kazdin (2000) associated with the development of serious mental health disorders in children. However, the EI/ECSE providers in these counties struggled with few resources to expand services.

As discussed earlier in Chapter IV, the focus on teachers' work with preschool-age children in the state-wide study may have been partly due to the research design, but it is likely that it is a solid finding because it was a topic that was selected by participants. A tentative conclusion can be drawn that in the majority of EI/ECSE agencies in the five

regions studied, strategies for working with children with mental health problems are associated with older children.

In contrast to where EI/ECSE providers focused their strategies for working with children, they always associated the foundation of children's mental health problems within their families. Many EI/ECSE and mental health providers identified the lack of mental health services for low-income parents as an urgent concern. EI/ECSE providers argued that they weren't trained as family counselors, and that mental health needed to fill this gap when dysfunctional family dynamics impeded their work with children.

The Barriers to Funding Mental Health Consultation in EI/ECSE

At this time, there appears to be no way for mental health agencies or private mental health therapists in Oregon to bill the public mental health system for consultation or prevention work. Although two regions hired behavior specialists with mental health backgrounds, it appears that most EI/ECSE agencies in rural areas do not have the resources to hire mental health consultants with their own funds. The EI/ECSE agency in the in-depth study used creative strategies to piece together a full-time position for its mental health consultant, but was able to benefit from only a small portion of her time.

It may be necessary for EI/ECSE agencies to advocate with the state Department of Education, mental health system, and Oregon legislature to increase understanding that resource-poor agencies in isolated counties need more support than they are receiving. In some parts of the state, these areas appear to describe greater than average mental health needs in their population of children and families.

Contributions to the Literature

Research in the early childhood mental health field has identified the need for the mental health system to be accessible to families with young children and to have providers who specialize in early childhood. In addition, recommendations for all personnel working with young children to improve their skills in supporting parent-child relationships, and in identifying and referring children and families to mental health have been strongly advocated (Fenichel, 1992; Knitzer, 2000). This study should make a significant contribution related to this literature in its descriptions of the capacity of the mental health system in Oregon, and the strategies used by EI/ECSE agencies.

Other contributions are being made to literature on the prevalence of serious behavioral and mental health problems in young children with disabilities. Although the information in this study is anecdotal and comes from EI/ECSE provider estimates, the consistency in estimates, and the reporting of the prevalence numbers in the context of agency characteristics is useful in an area that has little research. Descriptions of how EI/ECSE agencies identify children with challenging behaviors is also rare in the literature (Powell et al., 2007), and providers' descriptions in this study should contribute to a better understanding.

Limitations of the Study

Several limitations of the research can be identified. The first pertains to the research design and data gathering methods. The questionnaire used in the state-wide study was designed to gather focused information from a circumscribed pool of

participants (Miles & Huberman, 1994). However, the number of issues that the questionnaire attempted to cover was not well matched to the data collection methods. An attempt was made to gather too much information in too short a time. Consequently, the issues of most importance to the participant or to the researcher received the most attention. Although the use of an interview style that allowed participants' interests to lead the discussion was an optimal way of identifying the most pressing issues, it was not conducive to exploring important questions that were not brought up by participants.

The division of the study results into specific topics in Chapters IV through VI does not do justice to the interconnectedness of the themes and the contextual nature of agencies' solutions to mental health problems they face daily. The reductive nature of pulling out major themes robs the life from the narrative. An attempt was made to provide some picture of this complexity in the vignettes in Chapter IV and in the in-depth study in Chapter VI.

The second major limitation is that this study is based on specific participants' opinions at a snapshot in time. This is one of the important qualities of naturalistic research, but in this study the way that participants were chosen may have had an influence on the generalizable nature of the data. For example, two of the EI/ECSE coordinators were newly hired, and a third had worked for only a few years in the management position in her agency. Although staff turnover is a reality of the field, the information collected from these providers may not have been as useful as that gathered from providers who understood the long-term context of their work. The time limitations of the research study did not allow flexibility in pursuing more than one interview per

agency except in a few cases in which the researcher felt that an important issue needed clarification. In interviews of mental health providers, there was not enough time to interview providers in every county that had EI/ECSE interviews. Some of the mental health participants were in agencies that had gone through major overhauls, and had worked in the agencies for a limited number of years.

A related issue is the study's focus on perspectives of providers at the administrative level. There may have been some inflation in the descriptions of staff capabilities and effectiveness of strategies because administrators often don't work at the direct service level.

The third limitation is that the state-wide study covered only half of the regions in Oregon. It cannot be used to provide an overview of how EI/ECSE agencies throughout the state work with the mental health needs of their children and families. This limitation was due to time constraints.

Another innate limitation which may have weakened the results of the study was the researcher's working style. The researcher's long-practiced habits of independently working alone were contrary to the chosen research method. Qualitative research benefits from seeking input from other sources besides the researcher's own perspective. The researcher met periodically with advisors to keep them informed about the progress of the research, and sought advisors' help to make major decisions about the direction of data collection. However, regular discussions to bounce off identification of themes or to challenge researcher bias were not undertaken. To combat bias, the researcher returned to

the interview transcripts many times in an attempt to understand participants' concerns in context.

Future Directions

This research study is an initial exploration of a very complex subject. Many interviews provided rich information, and often provided an overall “gestalt” of how agencies in Oregon operated. However, the research must be viewed as based on initial conversations with participants.

Future work on this topic would certainly include collection of information on the the remaining four EI/ECSE regions in Oregon that weren't included in this study. A large proportion of rural counties were featured in the current study, and services likely vary in the additional agencies located in large metro areas.

Many of the participants in the study showed interest in a summary of the findings from other areas of the state. This implied to the researcher that there may not be adequate communication between agencies across the state that do not directly participate in contractor meetings or other topical meetings that occur statewide. A potential research topic would be to explore how well agencies communicate with each other across the state, and whether there is a need to establish a better communication system between small agencies that currently depend on their regional contractors for information.

Other topics arise that could be used to investigate ways of improving mental health services in EI/ECSE and other early childhood programs. In this study, agencies in different regions often have more in common than agencies within regions. More

research could be productive on identifying how agencies can work across regional boundaries on common needs.

Finally, and most importantly, there is consensus among EI/ECSE providers in their strong identification of the need to improve mental health services for children and families. There are many potential avenues to work on this issue at the state, regional, and county levels. It is believed that close collaborative working relationships will be an aspect of solutions for this problem. Of course it is naïve to believe that working relationships alone can solve problems in rural areas with few resources. Statewide or regional perspectives must be used to problem solve support for agencies that work in isolated, resource poor counties. A taskforce composed of EI/ECSE, mental health providers, and parents may be needed to strategize and approach the legislature with strategies to redesign funding and to support collaborative relationships that could form the basis of mental health and early childhood partnerships.

BIBLIOGRAPHY

- Administration on Children and Families. (2007). *Child maltreatment 2005*. Retrieved June 27, 2007, from <http://www.acf.hhs.gov/programs/cb/pubs/cm05/index.htm>
- Alkon, A., Ramler, M., & MacLennan, K. (2003). Evaluation of mental health consultation in child care centers. *Early Childhood Education Journal*, 31(2), 91-99.
- Allen, M. D., Friesen, B., Koontz, K., & Koroloff, N. (2006). *Oregon children's mental health system change initiative: Implementation evaluation. Report of findings. (Draft for review, October 10, 2006). Submitted to: Office of Mental Health & Addiction Services, Department of Human Services, Salem, Oregon.* Portland OR: Portland State University, Regional Research Institute for Human Services, Graduate School of Social Work.
- American Academy of Pediatrics (2000). Guiding principles for managed care arrangements for the health care of newborns, infants, children, adolescents, and young adults. *Pediatrics*, 105, 132-135.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.
- American Psychiatric Foundation. (2001). Significant achievement awards. *Psychiatric Services*, 52, 1386-1390. Retrieved March 31, 2008, from <http://www.psychservices.psychiatryonline.org/cgi/content/full/52/10/1386>
- American Psychological Association. (2003, February). *Resolution on the maltreatment of children with disabilities*. Retrieved June 27, 2007, from <http://www.apa.org/pi/disability/maltreatment.html>.
- Argyris, C. (1982). *Reasoning, learning and action: Individual and organizational*. San Francisco: Jossey-Bass.
- Baird, S., & Peterson, J. E. (1997). Seeking a comfortable fit between family-centered philosophy and infant-parent interaction in early intervention: Time for a paradigm shift? *Topics in Early Childhood Special Education*, 17(2), 139-164.
- Batshaw, M. L., & Perret, Y. M. (1992). *Children with disabilities: A medical primer* (3rd ed.). Baltimore: Brookes.
- Batshaw, M. L. (Ed.). (2002). *Children with disabilities* (5th ed.). Baltimore: Brookes.

- Beck, A. W. (1993). *The Beck depression inventory*. New York: Harcourt Brace.
- Berger, P. L., & Luckmann, T. (1966) *The social construction of reality: A treatise in the sociology of knowledge*. Garden City, NY: Doubleday.
- Bernstein, V. J., Campbell, S., & Akers, A. (2001). Caring for the caregivers. In J. N. Hughes, A. N. LaGreca, & J. C. Conoley, *Handbook of psychological services for children and adolescents* (pp. 107-131). New York: Oxford University Press.
- Bertalanffy, L. von. (1968). *General systems theory*. New York: Braziller.
- Billmire, M.E., & Myers, P. A. (1985). Serious head injury in infants: Accident or abuse? *Pediatrics*, 75(2), 340-342.
- Blacher, J., Lopez, S., Shapiro, J., & Fusco, J. (1997). Contributions to depression in Latina mothers with and without children with retardation: Implications for caregiving. *Family Relations*, 46(4), 325-334.
- Blackman, J. A., & Cobb, L. S. (1989). A comparison of parents' perceptions of common behavior problems in developmentally at-risk and normal children. *Children's Health Care*, 18(2), 108-113.
- Bogdan, R. C., & Biklen, S. K. (2003). *Qualitative research in education: An introduction to theory and methods* (4th ed.). Boston: Pearson.
- Bogdan, R., & Taylor, S. J. (1982). *Inside out: The social meaning of mental retardation*. Buffalo, NY: University of Toronto Press.
- Boss, P. G., Doherty, W. J., LaRossa, R., Schumm, W. R., & Steinmetz, S. K. (Eds.). (1993). *Sourcebook of family theories and methods: A contextual approach*. New York: Plenum.
- Bowe, F. G. (2004). *Early childhood special education: Birth to eight* (3rd ed.). New York: Delmar.
- Bowlby, J. (1951). *Maternal care and mental health* (Monograph Series No. 2). Geneva, Switzerland: World Health Organization.
- Brantlinger, E., Jimenez, R., Klingner, J., Pugach, M., & Richardson, V. (2005). Qualitative studies in special education. *Exceptional Children*, 71(2), 195-207.
- Brazelton, T. B., & Cramer, B. G. (1990). *The earliest relationship: Parents, infants, and the drama of early attachment*. Reading, MA: Addison-Wesley.

- Brennan, E., Bradley, J., Allen, M. D., Bennington, D., Perry, D. F., & Tsega, A. (2006). Addressing mental health in early childhood settings: The role of mental health consultation. In L. Gordon, J. Bradley, N. Aue, & A. Holman (Eds.), *Building on family strengths: Research and services in support of children and their families. 2005 conference proceedings*. Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health.
- Bricker, D. D. (1989). *Early intervention for at-risk and handicapped infants toddlers, and preschool children*. Palo Alto, CA: Vort.
- Campbell, S. B. (2002). *Behavior problems in preschool children: Clinical and developmental issues*. New York: Guilford.
- Center on the Social and Emotional Foundations for Early Learning (CSEFEL). (2008). *About us*. Retrieved April 23, 2008, from <http://www.vanderbilt.edu/csefel/>
- Cohen, E., & Kaufmann, R. (2005). *Early childhood mental health consultation* (DHHS Pub. No. CMHS-SVP0151). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- Crnic, K. A., Friedrich, W. N., & Greenberg, M. T. (1983). Adaptation of families with mentally retarded children: A model of stress, coping, and family ecology. *American Journal of Mental Deficiency, 88*(2), 125-138.
- Delgado, C. E. F., Vagi, S. J., & Scott, K. G. (2006). Tracking preschool children with developmental delay: Third grade outcomes. *American Journal on Mental Retardation, 111*(4), 299-306.
- DeMulder, E. K., & Radke-Yarrow, M. (1991). Attachment with affectively ill and well mothers: Concurrent behavioral correlates. *Development and Psychopathology, 3*, 227-242.
- Diamond, L. & Jaudes, P. (1983). Child abuse in a cerebral-palsied population. *Developmental Medicine and Child Neurology, 25*, 169-174.
- Dixon, W. E. (2003). *20 studies that revolutionized child psychology*. Upper Saddle River, NJ: Prentice Hall.
- Downey, G., & Coyne, J. C. (1990). Children of depressed parents: An integrative review. *Psychological Bulletin, 108*(1), 50-76.
- Drotar, D., & Sturm, L. (1991) Mental health intervention with infants and young children with behavioral and developmental problems. *Infants & Young Children, 3*(4), 1-11.

- Dunst, C. J., Trivette, C. M., & Deal, A. G. (1994). *Supporting and strengthening families. Vol. 1: Methods, strategies and practices*. Cambridge, MA: Brookline.
- EC CARES. (2006). *EC CARES provider handbook 2006-2007*. Retrieved May 6, 2007, from http://www.uoregon.edu/~ecweb/employees_only/Handbooks/ServiceProviderHandbook0607.pdf
- Erikson, E. (1950). *Childhood and society*. New York: Norton.
- Feinstein, C., & Reiss, A. L. (1996). Psychiatric disorders in mentally retarded children and adolescents. *Mental Retardation*, 5(4), 827-852.
- Fenichel, E. (Ed.) (1992). *Learning through supervision and mentorship to support the development of infants, toddlers and their families*. Arlington, VA: Zero to Three.
- Fenichel, E. S., Feinberg, E., & Delago, B. S. (1989). *Mental health services for infants and toddlers: A three-state perspective on the implementation of Part H of P.L. 99-457, The Education of the Handicapped Act Amendments of 1986*. Washington DC: CASSP Technical Assistance Center.
- Fitzgerald, H. E., & Barton, L. R. (2000). Infant mental health: Origins and emergence of an interdisciplinary field. In J. D. Osofsky & H. E. Fitzgerald (Eds.), *WAIMH handbook of infant mental health* (pp. 1-36). New York: Wiley.
- Foley, G. M. & Hochman, J. D. (2006). *Mental health in early intervention: Achieving unity in principles and practice*. Baltimore: Brookes.
- Fontana, A., & Frey, J. H. (2000). The interview: From structured questions to negotiated text. In Denzin, N. K., & Lincoln, Y. S. (2000). *Handbook of qualitative research* (2nd ed., pp. 645-672). Thousand Oaks, CA: Sage.
- Fraiberg, S. (1977). *Insights from the blind: Comparative studies of blind and sighted infants*. New York: Basic.
- Fraiberg, S. (Ed.) (1980). *Clinical studies in infant mental health: The first year of life*. New York: Basic.
- Friedman, R. M. (2001). The practice of psychology with children, adolescents, and their families: A look to the future. In J. N. Hughes, A. N. LaGreca, & J. C. Conoley, *Handbook of psychological services for children and adolescents* (pp. 3-22). New York: Oxford University Press.
- Garbarino, J. (1989). Maltreatment of young children with disabilities. *Infants & Young Children*, 2(2), 49-57.

- Gauthier, Y. (2000). Foreword. In J. D. Osofsky & H. E. Fitzgerald (Eds.), *WAIMH handbook of infant mental health* (pp. xiii-xvi). New York: Wiley.
- Gilkerson, L., & Kopel, C. C. (2005). Relationship-based systems change: Illinois' model for promoting social-emotional development in Part C early intervention. *Infants & Young Children, 18*(4), 349-365.
- Gilkerson, L., & Stott, F. (2000). Parent-child relationships in early intervention with infants and toddlers with disabilities and their families. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (pp. 457-471). New York: Guilford.
- Graham, M. A., White, B. A., Clarke, C. C., & Adams, S. (2001). Infusing mental health practices into front-line caregiving. *Zero to Three, 14*(1), 14-23.
- Green, B. L., Everhart, M., Gordon, L., & Gettman, M. G. (2006). Characteristics of effective mental health consultation in early childhood settings: Multilevel analysis of a national survey. *Topics in Early Childhood Special Education, 26*(3), 142-152.
- Greenspan, S. I., & Meisels, S. (1994). Toward a new vision of developmental assessment of infants and young children. *Zero to Three, 14*(6), 1-8.
- Greenspan, S. I., & Wieder, S. (1998). *The child with special needs*. Cambridge, MA: Perseus.
- Grossmann, K. E., Grossmann, K., & Waters, E. (2005). *Attachment from infancy to adulthood: The major longitudinal studies*. NY: Guilford.
- Guralnick, M. J. (2005). From the editor. *Infants & Young Children, 18*(4), 263.
- Guralnick, M. J., Neville, B., Connor, R. T., & Hammond, M. A. (2003). Family factors associated with the peer social competence of young children with mild delays. *American Journal on Mental Retardation, 108*(4), 272-287.
- Hanson, M. J., & Lynch, E. W. (2004). *Understanding families: Approaches to diversity, disability, and risk*. Baltimore: Brookes.
- Hebbeler, K., Wagner, M., Spiker, D., Scarborough, A., Simeonsson, R., Collier, M. (2001). *A first look at the characteristics of children and families entering early intervention services. NEILS data report 1*. Retrieved July 22, 2007, from <http://www.sri.com/neils/reports.html>
- Heller, T., Markwardt, R., Rowitz, L., & Farber, B. (1994). Adaptation of Hispanic families to a member with mental retardation. *American Journal of Mental Retardation, 99*(3), 289-300.

- Hibbard, R. A., Desch, L. W., Committee on Child Abuse and Neglect, & Council on Children with Disabilities. (2007). Maltreatment of children with disabilities. *Pediatrics*, 119(5), 1018-1025.
- Hirshberg, L. M. (1996). History-making, not history-taking: Clinical interviews with infants and their families. In S. J. Meisels & E. Fenichel (Eds.), *New visions for the developmental assessment of infants and young children* (pp. 85-124). Washington DC: Zero to Three.
- Hirshberg, L. M. (1998). Infant mental health consultation to early intervention programs. *Zero to Three*, December 1997-January 1998, 19-23.
- Hodapp, R. M. (1997). Direct and indirect behavioral effects of different genetic disorders of mental retardation. *American Journal on Mental Retardation*, 102, 67-79.
- Hodapp, R. M., & Burack, J. A. (2006). Developmental approaches to children with mental retardation: A second generation? In D. Cicchetti & D. J. Cohen, *Developmental psychopathology* (Vol. 3, pp. 235-267). New York: Wiley.
- Holland, M. L., & Merrell, K. W. (1998). Social-emotional characteristics of preschool-aged children referred for child find screening and assessment: A comparative study. *Research in Developmental Disabilities*, 19(2), 167-179.
- How to Read Your Baby. (2007). *Partners in parenting education*. Retrieved September 29, 2007, from <http://www.howtoreadyourbaby.org/PipeCurriculumandModel.html>
- International Society for the Systems Sciences. (2007). *Ludwig von Bertalanffy*. Retrieved June 14, 2007, from <http://www.iss.org/lumLVB.htm>
- Jellinek, M. S. (1999). Changes in the practice of child and adolescent psychiatry: Are our patients better served? *Journal of the American Academy of Child & Adolescent Psychiatry*, 38, 115-117.
- Jepson, C., & Nickel, R. E. (2000). Nutrition and growth. In R. E. Nickel & L. W. Desch (Eds.), *The physician's guide to caring for children with disabilities and chronic conditions* (pp. 77-98). Baltimore: Brookes.
- Kalmanson, B., & Seligman, S. (2006). Process in an integrated model of infant mental health and early intervention practice. In G. M. Foley & J. D. Hochman (Eds.), *Mental health in early intervention* (pp. 245-265). Baltimore: Brookes.
- Kaufmann, J. M. (1999). How we prevent the prevention of emotional and behavioral disorders. *Exceptional Children*, 65(4), 448-468.

- Kaufmann, R. F., & Hepburn, S. (2007). Early childhood mental health services and supports through a systems approach. In D. F. Perry, R. F. Kaufmann, & J. Knitzer (Eds.), *Social and emotional health in early childhood: Building bridges between services and systems*. Baltimore: Brookes.
- Kazdin, A. E. (1995). *Conduct disorders in childhood and adolescence*. Thousand Oaks, CA: Sage.
- Kazdin, A. E. (2000). Conduct disorder. In R. J. Morris & T. R. Kratochwill (Eds.), *The practice of child therapy* (3rd ed., pp. 199-230). Boston: Allyn & Bacon.
- Keeping Children & Families Safe Act 42 U.S.C. 5106a(b)(2)(A)(xxi) (2003).
- Keller, T. E, Spieker, S. J, Gilchrist, L. (2005). Patterns of risk and trajectories of preschool problem behaviors: A person-oriented analysis of attachment in context. *Development and Psychopathology*, 17(2), 349-384.
- Kelly, J. F., & Barnard, K. E. (2000). Assessment of parent-child interaction: Implications for early intervention. In J. P. Shonkoff & S. J. Meisels (Eds.), *Handbook of early childhood intervention* (2nd ed., pp. 258-289). New York: Cambridge University Press.
- Klein, N. K., & Gilkerson, L. (2000) Personnel preparation for early childhood intervention programs. In J. P. Shonkoff & S. J. Meisels (Eds.), *Handbook of early childhood intervention* (2nd ed., pp. 454-483). New York: Cambridge University Press.
- Knitzer, J. (1993). Children's mental health policy: Challenging the future. *Journal of Emotional & Behavioral Disorders*, 1(1), 8. Retrieved September 15, 2007, from Academic Search Premier database.
- Knitzer, J. (2000). Early childhood mental health services: A policy and systems development perspective. In J. P. Shonkoff & S. J. Meisels (Eds.), *Handbook of early childhood intervention* (2nd ed., pp. 416-438). New York: Cambridge University Press.
- Kutash, K., & Rivera, V. R. (1996). *What works in children's mental health services? Uncovering answers to critical questions*. Baltimore: Brookes.
- Lehman, C., Lambarth, C., & Pegel, R. (2006). Incredible Years and consultation program evaluation. In L. Gordon, J. Bradley, J., N. Aue, & A. Holman (Eds.), *Building on family strengths: Research and services in support of children and their families. 2005 conference proceedings*. Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health.

- Levine, R., & Fitzgerald, H. E. (1992). *Analysis of dynamic psychological systems* (Vol. 1). New York: Plenum.
- Lincoln, Y. S., & Guba, E. G. (1985). *Organizational theory and inquiry: The paradigm revolution*. Beverly Hills, CA: Sage.
- Magana, S., Schwartz, S. J., Rubert, M. P., & Szapocznik, J. (2006). Hispanic caregivers of adults with mental retardation: Importance for family functioning. *American Journal on Mental Retardation*, 11(4), 250-262.
- Mahler, M. S., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant*. New York: Basic.
- Mahoney, G., Spiker, D., & Boyce, G. (1996). Clinical assessments of parent-child interaction: Are professionals ready to implement this practice? *Topics in Early Childhood Special Education*, 16(1), 26-50.
- Mandt System. (2008). *The Mandt system*. Retrieved May 18, 2008, from <http://www.mandtsystem.com/index.php>
- McCollum, J. A., & Yates, T. J. (1994). Dyad as focus, triad a means: A family-centered approach to supporting parent-child interactions. *Infants & Young Children*, 6(4), 54-63.
- McCubbin, H. I., Thompson, E. A., Thompson, A. I., & McCubbin, M. A. (1993). Family schema, paradigms, and paradigm shifts: Components and processes of appraisal in family adaptation to crisis. In A. P. Turnbull, J. M. Patterson, S. H. Behr, D. L. Murphy, J. G. Marquis, & M. J. Blue-Banning (Eds.), *Cognitive coping, families, and disability* (pp. 239-255). Baltimore: Brookes.
- McCubbin, H. I., & Patterson, J. M. (1983). The family stress process: The Double ABCX Model of family adjustment and adaptation. *Marriage and Family Review*, 6, 7-37.
- McMillan, J. H. (2004). *Educational research: Fundamentals for the consumer* (4th ed). Boston: Pearson.
- Merrell, K. W. (2003). *Behavioral, social, and emotional assessment of children and adolescents*. Mahwah, NJ: Erlbaum
- Meyers, J. C. (2007). Developing the work force for an infant and early childhood mental health system of care. In D. F. Perry, R. F. Kaufmann, & J. Knitzer, *Social & emotional health in early childhood: Building bridges between services & systems* (pp. 97-120). Baltimore: Brookes.

- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.
- Minnes, P. (1988). Family stress associated with a developmentally handicapped child. *International Review of Research on Mental Retardation*, 15, 195-226.
- Moran, D. (2000). *Introduction to phenomenology*. New York: Routledge.
- Moss, B., & Gotts, E. A. (December 1997-January 1998). Relationship-based early childhood intervention: A progress report from the trenches. *Zero to Three*, 24-32.
- Mrazek, P. J., & Haggerty, R. J. (Eds.). (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Washington, DC: National Academy Press.
- National Institute of Child and Human Development Early Childhood Research Network ([NICHD], 1999). Chronicity of maternal depressive symptoms, maternal sensitivity, and child functioning at 36 months. *Developmental Psychology*, 35(5), 1297-1310.
- Nickel, R. E. (2000). Developmental delay and mental retardation. In R. E. Nickel & L. W. Desch (Eds.), *The physician's guide to caring for children with disabilities and chronic conditions* (pp. 99-140). Baltimore: Brookes.
- Odom, S. L., McConnell, S. R., & McEvoy, M. A. (1992). *Social competence of young children with disabilities: Issues and strategies for intervention*. Baltimore: Brookes.
- Offord, D. R., Kraemer, H. C., Kazdin, A. E., Jenson, P. S., & Harrington, R. (1998). Lowering the burden of suffering from child psychiatric disorder: Trade-offs among clinical, targeted, and universal interventions. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 686-694.
- Olshansky, S. (1962). Chronic sorrow: A response to having a mentally defective child. *Social Casework*, 43, 190-193.
- Olshansky, S. (1966). Parent responses to a mentally defective child. *Mental Retardation*, 4, 21-23.
- Oregon Department of Education, Early Intervention and Early Childhood Special Education (EI/ECSE). (2007). *EI/ECSE policies and procedures*. Retrieved April 23, 2007, from http://www.ode.state.or.us/gradelevel/pre_k/eiecse/pdfs/eipolicyandproc.pdf
- Oregon Department of Education, EI/ECSE Map. (2008). *EI/ECSE service areas*. Retrieved January 5, 2008, from <http://www.ode.state.or.us/search/page/?id=1847>

- Oregon Department of Education, EI/ECSE Services in Oregon. (2007). *New EI/ECSE referral and evaluation brochures*. Retrieved April 23, 2007, from http://www.ode.state.or.us/gradelevel/pre_k/eiecse/eiecsebroch.aspx
- Oregon Department of Education, Office of Student Learning and Partnerships. (2007). *About EI/ECSE services*. Retrieved April 23, 2007, from <http://www.ode.state.or.us/search/page/?id=551>
- Oregon Department of Human Services. (2005). *The status of children in Oregon's child protection system 2005*. Retrieved April 24, 2007, from <http://dhsforms.hr.state.or.us/Forms/Served/DE1535.pdf>
- Oregon Department of Human Services. (2007). *The status of children in Oregon's child protective system 2006*. Retrieved June 30, 2007, from <http://www.oregon.gov/DHS/abuse/publications/children/abusestats2006.pdf>.
- Oregon Department of Human Services, Mental Health. (2007). *State incentive grant: Enhancement for early childhood prevention*. Retrieved April 24, 2007, from <http://www.oregon.gov/DHS/mentalhealth/ecp/main.shtml>
- Oregon Department of Human Services, Mental Health. (2008). *Evidence-based practices (EBP)*. Retrieved March 31, 2008, from <http://www.oregon.gov/DHS/mentalhealth/ebp/main.shtml>
- Oregon Developmental Disabilities. (2007). *Developmental disabilities abuse and neglect*. Retrieved June 30, 2007, from <http://www.oregon.gov/DHS/dd/abuse/index.shtml>.
- Patterson, J. M. (1993). The role of family meanings in adaptation to chronic illness and disability. In A. P. Turnbull, J. M. Patterson, S. H. Behr, D. L. Murphy, J. G. Marquis, & M. J. Blue-Banning (Eds.), *Cognitive coping, families, and disability* (pp. 221-238). Baltimore: Brookes.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Pears, K., & Fisher, P. (2005). Developmental, cognitive, and neuropsychological functioning in preschool-aged foster children: Associations with prior maltreatment and placement history. *Journal of Developmental and Behavioral Pediatrics*, 26, 112-122.
- Perry, D. F., Kaufmann, R. F., & Knitzer, J. (Eds.). (2007). *Social and emotional health in early childhood: Building bridges between services and systems*. Baltimore: Brookes.

- Phelan, T. W. (2004). *1-2-3 magic: Effective discipline for children 2-12*. Glen Ellyn, IL: Parentmagic, Inc.
- Pianta, R. C. (2001). Implications of a developmental systems model for preventing and treating behavioral disturbances in children and adolescents. In J. N. Hughes, A. N. LaGreca, & J. C. Conoley, *Handbook of psychological services for children and adolescents* (pp. 23-41). New York: Oxford University Press.
- Psathas, G. (1973). Introduction. In G. Psathas (Ed.), *Phenomenological sociology: Issues and applications*. New York: Wiley.
- Qi, C. H., & Kaiser, A. P. (2003). Behavior problems of preschool children from low-income families. *Topics in Early Childhood Special Education*, 23(4), 188-216.
- Radloff, L. S. (1977). The Center for Epidemiological Studies Depression Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385-401.
- Ratnofsky, A., & Crosse, S. (1991). *The maltreatment of children with disabilities and child maltreatment in substance abusing families*. National Data Archive on Child Abuse and Neglect. Retrieved June 28, 2007, from http://www.ndacan.cornell.edu/NDACAN/Datasets/Abstracts/DatasetAbstract_68.html.
- Reams, R. (2006, September 22). *Child temperament, parenting styles, and family dynamics: Improving social-emotional competence in young children*. Infant Mental Health Conference, Lane Community College, Eugene, OR.
- Region 3 EI/ECSE. (2003). *Guidelines for determining eligibility for early intervention/early childhood special education programs in Oregon*. (Available from Region 3 EI/ECSE, Douglas ESD, Roseburg, OR).
- Reinharz, S. (1992). *Feminist methods in social research*. New York: Oxford University Press.
- Riccio, C. A., & Hughes, J. N. (2001). Established and emerging models of psychological services in school settings. In J. N. Hughes, A. N. LaGreca, & J. C. Conoley, *Handbook of psychological services for children and adolescents* (pp. 63-87). New York: Oxford University Press.
- Robert-Tissot, C., Cramer, B., Stern, D. N., Serpa, S. R., Bachmann, J. P., Palacio-Espasa, F., Knauer, D., De Mural, M., Berney, C., & Mendiguren, G. (1996). Outcome evaluation of brief mother-infant psychotherapies: Report on 75 cases. *Infant Mental Health Journal*, 17(2), 97-114.

- Rogers-Dulan, J. (1998). Religious connectedness among urban African American families who have a child with disabilities. *Mental Retardation*, 36(s), 91-103.
- Rutter, M., Graham, P., & Yule, W. (1970). A neuropsychiatric study in childhood. *Clinics in Developmental Medicine*, 35/36. Philadelphia: Lippincott.
- Sameroff, A. J., & Fiese, B. H. (2000). Models of development and developmental risk. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (2nd ed., pp. 3-19). New York: Guilford.
- Sameroff, A. J., Seifer, R., Baldwin, A., Baldwin, C. (1993). Stability of intelligence from preschool to adolescence: The influence of social and family risk factors. *Child Development*, 64(1), 80-97.
- Sandall, S., McLean, M. E., & Smith, B. J. (2000). *DEC recommended practices in early intervention/early childhood special education*. Denver: Division for Early Childhood of the Council for Exceptional Children.
- Schutz, A. (1967). *The phenomenology of the social world*. Chicago: Northwestern University Press.
- Seifer, R. (1995). The perils and pitfalls of high-risk research. *Developmental Psychology*, 31, 420-424.
- Seifer, R., Sameroff, A. J., Baldwin, C., & Baldwin, A. L. (1992). Child and family factors that ameliorate risk between 4 and 13 years of age. *Journal of the American Academy of Child & Adolescent Psychiatry*, 31(5), 893-903.
- Severson, H. H., & Walker, H. M. (2002). Proactive approaches for identifying children at risk for sociobehavioral problems. In K. L. Lane, F. M. Gresham, & T. E. O'Shaughnessy (Eds.), *Intervention for children with or at-risk for emotional and behavioral disorders* (pp. 33-53). Boston: Allyn & Bacon.
- Shackelford, J. (2006). *State and jurisdictional eligibility definition for infants and toddlers with disabilities under IDEA (NECTAC Notes No. 21)*. Chapel Hill: University of North Carolina, FPG Child Development Institute, National Early Childhood Technical Assistance Center. Retrieved May 6, 2007, from <http://www.nectac.org/%7Epdfs/pubs/nnotes21.pdf>
- Shonkoff, J. P., Lippitt, J. A., & Cavanaugh, D. A. (2000). Early childhood policy: Implications for infant mental health. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (2nd ed., pp. 503-518). New York: Guilford.

- Shonkoff, J. P., & Phillips, D. A. (Eds.) (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.
- Singer, G. H. S. (1993). When it's not so easy to change your mind: Some reflections on cognitive interventions for parents of children with disabilities. In A. P. Turnbull, J. M. Patterson, S. H. Behr, D. L. Murphy, J. G. Marquis, & M. J. Blue-Banning (Eds.), *Cognitive coping, families, and disability* (pp. 207-220). Baltimore: Brookes.
- Singer, G. H. S. (2006). Meta-analysis of comparative studies of depression in mothers of children with and without developmental disabilities. *American Journal of Mental Retardation*, 111(3), 155-169.
- Singer, G. H. S., & Irvin, L. K. (1991). Supporting persons with severe disabilities: Emerging findings, practices, and questions. In L. H. Meyer, C. A. Peck, & L. Brown (Eds.), *Critical issues in the lives of people with severe disabilities* (pp. 271-312). Baltimore: Brookes.
- Slentz, K. L., & Bricker, D. (1992). Family-guided assessment for IFSP development: Jumping off the family assessment bandwagon. *Journal of Early Intervention*, 16(1), 11-19.
- Sobsey, D. (1994). *Violence and abuse in the lives of people with disabilities: The end of silent acceptance?* Baltimore: Brookes.
- Solnit, A., & Stark, M. (1961). Mourning and the birth of a defective child. *Psychoanalytic Study of the Child*, 16, 523-537.
- Steele, L. S. (1998). Integrating infant mental health practices into Part H: Evolution of a local early intervention program. *Infants & Young Children*, 11(1), 73-83.
- Steinberg, M. A., & Hylton, J. R. (1998). *Responding to maltreatment of children with disabilities: A trainer's guide*. Portland, OR: Oregon Health Sciences University.
- Stern, D. N. (1985). *The interpersonal world of the infant*. New York: Basic.
- Stroul, B.A., & Friedman, R. M. (1986). *A system of care for seriously emotionally disturbed children and youth*. Washington, DC: Georgetown University Child Development Center.
- Sullivan, P. M., & Knutson, J. F. (2000). Maltreatment and disabilities: A population-based epidemiologic study. *Child Abuse & Neglect*, 24, 1257-1273.
- Taylor, E. (2003). Practice methods for working with children who have biologically-based mental disorders: A bioecological model. *Families in Society*, 84(1), 39-50.

- Thompson, L. (1992). Feminist methodology for family studies. *Journal of Marriage & the Family*, 54(1), 3-18.
- Turnbull, A. P., Patterson, J. M., Behr, S. K., Murphy, D. L., Marquis, J. G., & Blue-Banning, M. J. (Eds.). (1993). *Cognitive coping, families, and disability*. Baltimore: Brookes.
- Turnbull, A. P., & Turnbull, R. (1986). Stepping back from early intervention: An ethical perspective. *Journal of the Division for Early Childhood*, 10(2), 106-118.
- Twenty-third Annual Report to Congress. (2001). *Characteristics of children and families entering early intervention (2001)*. Retrieved July 22, 2007, from The National Early Intervention Longitudinal Study at <http://www.sri.com/neils/reports.html>
- Twenty-fourth Annual Report to Congress. (2002). *Results experienced by children and families 1 year after beginning early intervention*. Retrieved July 22, 2007, from The National Early Intervention Longitudinal Study at <http://www.sri.com/neils/reports.html>
- U.S. Surgeon General. (1999). *Mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services.
- Wagner, M., Kutash, K., Duchnowski, A. J., Epstein, M. H., & Sumi, W. C. (2005). The children and youth we serve: A national picture of the characteristics of students with emotional disturbances receiving special education. *Journal of Emotional and Behavioral Disorders*, 13(2), 79-96.
- Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds: High risk children from birth to adulthood*. Ithaca, NY: Cornell University Press.
- Westat Corporation (1993) *The incidence of maltreatment among children with disabilities*. Washington, DC: National Center on Child Abuse and Neglect.
- Weston, D. E. (2005). Training in infant mental health: Educating the reflective practitioner. *Infants & Young Children*, 18(4), 337-348.
- Weston, D. E., Ivins, B., Heffron, M. C., & Sweet, N. (1997). Reformulating the centrality of relationships in early intervention: An organizational perspective. *Infants & Young Children*, 9(3), 1-12.
- Winton, P., McCollum, J., & Catlett, C. (Eds.). (1997). *Reforming personnel preparation in early intervention: Issues, models, and practical strategies*. Baltimore, MD: Brookes.

- Wolery, M. (2000). Behavioral and educational approaches to early intervention. In J. P. Shonkoff & S. J. Meisels (Eds.), *Handbook of early childhood intervention* (pp. 179-203). New York: Cambridge University Press.
- Yoshikawa, H., & Knitzer, J. (1997). *Lessons from the field: Head Start mental health strategies to meet challenging needs*. New York: National Center for Children in Poverty.
- Zahn-Waxler, C., Duggal, S., & Gruber, R. (2002). Parental psychopathology. In M. H. Bornstein, *Handbook of parenting. Vol. 4: Social conditions and applied parenting* (2nd ed., pp. 295-327). Mahwah, NJ: Erlbaum.
- Zeanah, C. H. (Ed.). (2000). *Handbook of infant mental health* (2nd ed.). New York: Guilford.
- Zeanah, P. D., Larrieu, J. A., & Zeanah, C. H. (2000). Training in infant mental health. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (2nd ed., pp. 548-558). New York: Guilford.