

A FORMATIVE EVALUATION OF A SYSTEMIC INFANT MENTAL HEALTH PROGRAM
DESIGNED TO TREAT INFANTS AND THEIR FAMILIES THROUGH A
RURAL COMMUNITY MENTAL HEALTH CENTER

by

COREY DALE SCHLIEP

B.S., Washburn University, 1998

M.S., Friends University, 2001

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

Department of Family Studies and Human Services
College of Human Ecology

KANSAS STATE UNIVERSITY
Manhattan, Kansas

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Abstract

Despite the intensified research efforts into the field of Infant Mental Health and Marriage and Family Therapy, a truly systemically designed program has not been developed. This formative evaluation study illuminates the design phase, its developmental process, and the professional staff member's experience of this newly implemented "Options" program.

I focused specifically on Crawford County Community Mental Health Center's innovative systemic approach to issues related to infant mental health. In this body of work, I describe the process of creating this innovative approach, identified how the program originators made decisions about their approach and how the approach is being operationalized on a daily basis by interviewing the clinicians, who are providing the services and the administrators who created and oversee the program.

I utilized a qualitative approach in the design, transcription categorization, and data analysis. This formative evaluation used the "flashback approach" to tell the story of the evaluation findings, this included an Executive Summary. This study's exploration yielded a clearer understanding of the developmental process of the infant mental health program and its initial implementation.

The results of this evaluation revealed that there are a number of core program components (three levels of focus: child and family, program, and community and catchment area) that were organized and clearly disseminated throughout the staff. The interviews revealed that the program has encountered problematic issues including; policy and procedural agreements and mandates, staff turnover, program ownership and funding limitations. It grew increasingly clear that the value of the program's positive

impact on families outweighed the perceived hassle of establishing and implementing the program.

This evaluation produced a number of program recommendations for program perpetuation and potential improvements. The program recommendations addressed the challenges facing the “Options Program” are explained. The future research implications of this formative evaluation are enumerated.

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Approved by:

Co-Major Professor
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Table of Contents

List of Figures	ix
List of Tables	x
Acknowledgements.....	xi
CHAPTER 1 - Introduction	1
Overview of Issues.....	1
Traditional Approaches.....	5
Traditional Interventions.....	6
Purpose of the Study	7
Guiding Framework	8
Gap in Current Theories.....	12
Brief Description of Methodology	14
Research Question	15
Limitations of the study	16
Conclusions.....	16
CHAPTER 2 - Literature Review	19
Wave One: History of Infant Mental Health Clinical Work.....	20
Theories of Most Relevance	24
Traditional Clinical Approaches to address IMH Concerns	37
Promotional/Prevention Approaches	53
Wave Two: Marriage and Family Therapy’s history of working with zero to three population	58
Theories of most relevance	62
Traditional Clinical Approaches for MFTs to address presenting IMH Concerns ..	67
Wave Three: Community Mental Health Centers	72
Rural Community Mental Health Centers	74
Summary of Wave Three	80
Wave Four: Community Mental Health Center of Crawford County (CMHCCC).....	81
History and rationale for new IMH services.....	81

Summary of Wave Four	82
CHAPTER 3 - Methodology	83
Research Design.....	84
Evaluation Design Considerations	87
Population and Sample	88
Protection of Human Subjects	90
Means of Data Collection	92
Means of Data Analysis	93
Reliability and Validity.....	95
Limitations	97
CHAPTER 4 - Results	99
An Overview of the Options Program’s Current Status	101
An Overview of the Program’s Developmental Process	109
Historical Overview of the Program.....	114
Program Summary 2003	115
Program Summary 2004	119
Program Summary 2005	123
Program Summary 2006	129
Program Summary 2007	134
Participant’s Perception and Experience of the Program’s Development	139
My Experience with the Interviews and Data Collection	167
CHAPTER 5 - Discussion	170
Appendix A - Kansas State University Informed Consent Form	198
Appendix B - Interview Guide (Administrators).....	202
Appendix C - Interview Guide (Staff)	207
Appendix D - Debriefing Handout	212
Appendix F: Formal Agency Agreement.....	215
Appendix G: Contracted Research Agreement.....	222
References.....	234

List of Figures

Figure 2-1 Ecological Map for Rural Mental Health for Services for Infants and Their Families	65
Figure 5-1 Michigan 4-Level Endorsement System (www.mi-aimh.org , 2008).....	190

List of Tables

Table 1.1 Model Comparison	11
Table 4.1 This is a reference to the required childcare staff/child ratio for the State of Kansas (<i>Kansas Department of Health and Environment, 2008</i>).....	103

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CHAPTER 1 - Introduction

Overview of Issues

The thought of working in a clinical manner with young children, especially those under the age of three who are preverbal, within the context of a family therapy session, has recently begun receiving more consideration in a few select professional journals. For many professionals the thought of the mere existence of a combination of mental health issues and infants seems inconceivable and leaves them feeling quite uncomfortable (Zeanah, 1993). There has been a void in the acknowledgment of the valuable role that the internal world of the infant, and the importance of the overall mental health of the infant, plays in the healthy beginnings in life. Properly addressing the early warning signs of mental health issues greatly assists infants and their families to create a stable foundation on which to develop (Zeanah, 1993, 2000).

The very young children in America, and in many places around the globe, are often overlooked when it comes to assessing, designing, and carrying out early intervention with mental health issues (Osofsky, Kronenberg, Hammer, Lederman, Katz, Adams, Graham, Hogan, 2007). Many professionals may believe that whatever early symptoms are observed in a young child will diminish through maturation, or that the child is just too young to directly treat (Kindred, 2003; Osofsky et al., 2007; Schliep, 2005). This attitude runs against what research tells us about the importance of early human development and the importance of early identification and intervention (Bricker, Schoen Davis, & Squires, 2004; *Center for Early Education and Development*, 2005;

Kirshenbaum, 1983; Maldonado-Duran, Lartigue, & Feintuch, 2000; Watson et al., 1999).

One facet of early human development critical in the quality of the mental health of infants is the brain. The brain is the only use dependent organ at birth and the brain grows depending on their biological inheritance and the environmental context they are in (Perry, Pollard, Blakley, Baker, & Vigilante, 1996). The early experiences, beginning prenatally, influence the young child's brain stem development, which is the state-regulating part of the brain and also the least plastic part of the brain. If the prenatal period is excessively stressful, or if there are harmful chemicals being passed on to the unborn child, the structural development of the brain, beginning with the brain stem, will not be as successful as that of a child's brain that has not been through such stressors (Maldonado-Duran, Lartigue et al., 2000; Perry et al., 1996). If the structure of the brain is not properly formed prenatally, a state of desynchronization is created in the child's primary brain functioning, such as lung functioning and heart rate (Perry et al., 1996). According to Siegel (1999), "The structure of the brain gives it an innate capacity to modulate emotion and to organize its states of activation. Sometimes referred to as 'affect regulation,' this capacity is crucial for the internal and interpersonal functioning of the individual" (Siegel, 1999 p.241). This can greatly impact the individual's state of mind as they grow and develop, including increasing the likelihood that the individual will suffer from any number of psychiatric disturbances (Siegel, 1999).

Prenatal and early childhood experiences and/or traumatic experiences are going to impact the mental health of the young child and how mental health services are created

and made available to address the concerns of the family and the very young among us as they grow and mature (Perry et al., 1996).

The prevalence of mental health issues in very young children is far too staggering to overlook. The recent research statistics, regarding the number of young children being identified as having mental health problems, have been found to be between 10 and 25% within the general population (Bricker et al., 2004). The mental health problems are classified as being that of “mild to severe social-emotional disorders” (Bricker et al., 2004 p.132). That number is considered to be higher in populations where the children suffer from disabilities and those who are in higher poverty areas (Bricker et al., 2004). Bricker et al. (2004) also suggested that these statistics are higher within rural and minority populations (Bricker et al., 2004). According to Osofsky (2007), the rates of mental health issues were measurably higher among abused and neglected populations than in those children where abuse and neglect were not present (Osofsky et al., 2007).

There is little data available about the rates of emotional problems present, specifically within children under the age of three. Zigler (2004) believes that this is mainly due to “a lack of an agreed upon classification system and methodology” (Zigler & Styfco, 2004 p.181). Without that agreed upon classification system and common methodology, practitioners can’t identify those young children who meet the criteria for having mild to severe social-emotional disorders. To take it a step further, without the common methodology and an agreed upon classification system, there is a lack of trained clinicians who are able to identify the early warning signs in young children and there is a general lack of community awareness of the issues facing young children. As a consequence, there also seems to be a lack of professional connectivity within

communities that greatly hinders their ability to look outside of their professional scope to accurately identify and address mental health issues in young children and their families.

An individual's physical health and emotional health are inseparable, especially in early childhood. Zeanah (1993, 2000) also believes that, if you selectively examine one, in the absence of the other, you will negatively influence the other (Zeanah, 1993). The National Health Interview Survey on Children's Health (1998) indicated that seven percent of all children, under the age of one, and five percent of all children, between one and two years of age, had no usual place for routine health care. The National Health Interview Survey on Children's Health (1998) also shows us that very young children in rural areas are less likely to be immunized than their urban counterparts. The fewer direct interactions children have with professionals the less likely it is that the child's emotional and physical health can be properly examined (Lieberman, 1992). This leaves young children, especially dwelling in rural areas, more susceptible to having their early warning signs of physical and emotional difficulties overlooked.

There is also a heavy stigma that surrounds mental health issues that creates additional obstacles for families who have concerns regarding their young children (Hinshaw, 2005). The stigma of mental illness crosses all social classes, races, ethnic groups, and is not restricted to geographic regions, populations, or a particular age range (Hinshaw, 2005). David Satcher, the Surgeon General of the United States from 1998 to 2002, strongly believes that the mental health field's number one problem and obstacle to overcome is that of the negative stigmatization of mental illness (United States Department of Health and Human Services, 1999). Other barriers to early childhood

mental health services include, but are not limited to, policy related barriers, lack of parental awareness, parents' not accurately reporting an/or seeking treatment and, if they don't properly identify early signs they can not seek early services, inaccurately identifying causal affects (mostly blamed on parents early in the 20th century and still occurs today) and, finally, a lack of child-focused assessments and interventions to which they can refer when early warning signs are detected (Owens et al., 2002). "In the United States, approximately 70% of children and adolescents in need of treatment do not receive mental health services," (Kazdin, Holland, Crowley, & Breton, 1997 p.1051). In order to increase the number of children, who are accurately identified as having early warning signs for mental health issues, it seems to me that we need to begin focusing our efforts on de-stigmatizing early mental health services, while simultaneously developing more effective preventative, assessment, and treatment programs for the zero to three population and their families.

Traditional Approaches

Psychoanalytic therapists have been identified traditionally for their ability and willingness to recognize the importance of the direct inclusion of young children in the therapy process. They have reportedly been more successful in working with the clinical issues that typically present themselves during the infancy period (such as feeding, sleeping, behavior disturbances, and attachment related issues, etc...) and within the parent/caregiver-infant relationship. Even though the field of Marriage and Family Therapy (MFT) has taken the most comprehensive systemic approach to the therapeutic realm, the literature reveals the absence of young children from therapy (Lojkasek, Cohen, & Muir, 1994; Lund, Schindler Zimmerman, & Haddock, 2002; Mackenzie,

2003). When children are shown to be present, their influence and experiences are most often given little attention. When their influence is considered, typically it has been after the children become verbal or the therapist is directly working with the parental unit or primary caregiver(s) to address their parental concerns and offer them guidance and support (Chasin & White, 2003; Ford Sori & Sprenkle, 2004; Lojkasek et al., 1994; Lund et al., 2002; Miller & McLeod, 2001).

Traditional Interventions

There has been a growing recognition of the importance of early identification and assessment and the number of available assessment and treatment options have dramatically increased during the last thirty years. The most common interventions are those focusing on the mother-child interaction: *Parent-Child Psychotherapy* (Fraiberg, 1959; Lieberman, 1992), Watch, Wait, and Wonder; and *Psycho-Dynamic* program level interventions (Interactional Guidance; and Circle of Security). There have also been early childhood programs that are *Promotion/Prevention Programs*, such as Parents as Teachers, and Early Head Start that are designed to partner families with early childhood educators. This partnership is created to promote optimum environments within which children may mature, to accomplish specific developmental goals, and to detect early warning signs for any possible deficits (emotionally, physically, and/or cognitively) that could hinder the child's overall development.

There is a paucity of literature available, regarding the positive impact of utilizing a systems approach, within the Marriage and Family Therapy (MFT) models, for the effective treatment and/or inclusion in treatment of young children in therapy. There are a few scholarly articles available that represent theory, suggestions, and techniques for use

with children in therapy (Lund et al., 2002; Miller & McLeod, 2001; Sved-Williams, 2003). Unfortunately, the scholarly articles, that have shown strong indications for the successful inclusion of young children in therapy, have not been put into practice on the front lines by MFT practitioners (Lund et al., 2002; Sved-Williams, 2003). There is also a lack of studies and evaluations that have been done on programs that treat and/or include young children in therapy.

Purpose of the Study

The purpose of this study is to understand the process of creating and operationalizing a systemically based, infant mental health program by conducting a formative evaluation of the Community Mental Health Center of Crawford County's (CMHCCC) infant mental health program. In this study, I will look at the available literature in order to identify the historical and theoretical approaches to addressing infant mental health problems and identify the salient approaches that have been utilized to address the most commonly identified presenting problems. I will be focusing specifically on Crawford County Community Mental Health Center's innovative systemic approach to issues related to infant mental health. In this body of work, I will describe the process of creating this innovative approach, identifying how the program originators made decisions about their approach and how the approach is being operationalized on a daily basis by interviewing the clinicians, who are providing the services and the administrators who created and oversee the program. To best accomplish this goal, I have chosen to conduct a formative evaluation on their program and report some initial findings from the program as they have now been in operation for over a year.

The Crawford County Community Mental Health Center is located in Southeastern rural Kansas, and therefore, I will also be describing the rural context and how that has uniquely influenced this mental health center's approach.

Guiding Framework

The creation of the organizing framework was guided by the overarching Ecological Theory, through the lens of Bronfenbrenner (Bronfenbrenner, 1979; Bronfenbrenner & Evans, 2000). This framework remains static in the integration process, based on its ability to organize multiple treatment modalities and approaches for the greatest degree of diversity in cultures, populations, and vastly different presenting issues. This framework is also valuable in creating an organizational structure and for theory development for designing family interventions (Bubolz & Sontag, 1993). The word "ecology" is used to describe the mutual relationships between organisms and their environment (Bronfenbrenner, 1979; Bubolz & Sontag, 1993). Based on that understanding of what ecology is defined to be, the Ecological Theory then can be utilized to gain a holistic understanding of the interconnectedness of relationships, whether it is focusing on the individual, group, or the institution level. There is so much to understand, about the complexities of people and the environments where they live and the entangled nature of the relationship of the two, that, apart from the combined efforts of professionals from different fields of study, we would limit the potential outcomes from the gained understanding from the different fields of study as the varying layers of the Ecological framework are evaluated.

This organizational framework has an assumption about there being a larger contextual framework present for everyone and it assumes that there are pressures,

expectations, and an inherent layering of concepts present. This framework also has strong developmental overtones that illuminate the family life cycle stages, such as those suggested by Carter and McGoldrick (1980) and developmental shifts between developmental stages, how each member of the family transitions between stages, and how each member is impacted by the development (or developmental concerns) of the others (Olsen, 1993). This allows a sense of prediction to the development of each family member and this predictability allows for increased awareness of what is going on and allows for appropriate planning to occur (Brazelton, 1992; Olsen, 1993). It should be noted that, from the Ecological Theory's perspective, family dynamics and the issues that are being presented within each unique family system are constantly evolving (Gagliardi, Guise, & Vickers, 1997).

In addition to the Ecological Framework, I have also utilized the principles of "Developmental Psychopathology" to inform my approach to this evaluation project. Developmental Psychopathology is defined as being the study and prediction of maladaptive behaviors and processes over time (Cicchetti & Cohen, 1995; Cummings, Davies, & Campbell, 2000). Developmental Psychopathology helps to make sense of children's behaviors and their social and emotional competence in a way that works to establish developmental norms and determine how each child's behaviors deviate from the established norm (Bricker et al., 2004; Cicchetti & Cohen, 1995; Ollendick & Hersen, 1983). "Normal" is established on a continuum, based on adaptations made over time, and then the adaptations that are made are placed on a normal-abnormal continuum (Achenbach, 1997). One adaptive behavior can be seen as normal during one developmental juncture but, if it continues into another later developmental point, the

once identified adaptive behavior becomes maladaptive (Achenbach, 1997). One behavior, within one particular context, can be identified as being normal, due to the peer group being compared, the relational/interactional dynamics taking place at the time, the one person's perspective for that point in time, and/or the situation in which the behavior manifests itself (Achenbach, 1997). For any particular child's behaviors to meet criteria for psychopathology, there has to be normed data to which we can compare the behavior (Achenbach, 1997). For an example, identifying one behavior at a childcare facility should not meet a standard for psychopathology, without first observing the child's behavior on a different day in the same context, with different people around, or in a different context, and with different activities taking place, with different people observing the behaviors (Achenbach, 1997).

The Developmental Psychopathology model is different from the more traditional Medical Model. Below you will see a chart displaying the unique distinctions for both models in a side-by-side comparison.

Table 1.1 Model Comparison

<p align="center">Medical (disease) Model</p>	<p align="center">Developmental Psychopathology Model</p>
<p>Disorders are distinct entities that differ qualitatively from normal development;</p>	<p>Problems in development are dimensional, with no clear demarcation between normal and disordered development;</p>
<p>There is a one-to-one correspondence between a disorder and a few identifiable causative factors;</p>	<p>Many risk and protective factors interact in the development of disorders, and these factors are related to the outcomes in a probabilistic fashion;</p>
<p>There is a single pathway to the development of a disorder;</p>	<p>There are multiple pathways to the development of a disorder;</p>
<p>The same pathway always results in the same disorder;</p>	<p>The same developmental pathway can result in multiple outcomes;</p>
<p>Normal and abnormal development are separate and distinct pathways;</p>	<p>Abnormal development can be explained by normal developmental processes;</p>

This comparison of models chart was developed by Dr. Ann Murray at Kansas State University

(Murray, 2006)

Gap in Current Theories

Early childhood mental health issues frequently go unidentified far longer than the mental health issues of school-aged children. The current interventions focus primarily on the parent-child relationship, examining the attachment style, interactional dynamics, parenting style, the child's temperament, and the impact the parent's mental health has on the child. There is a growing body of work that adds to this process by further examining the bi-directional nature of the influence in between family members, including the influence the infant has on other family members. Instead of solely treating the parent-child dyad, newer approaches are addressing the family system as a whole.

The impact of risk factors and protective factors are best understood with an ecological-transactional framework (Bronfenbrenner, 1979; Cicchetti & Cohen, 1995) that is informed by the tenets of Developmental Psychopathology (Cicchetti & Cohen, 1995; DelCarmen-Wiggins, 2001). Without a community wide, systemic approach to the identification and treatment of the mental health and development of young children, children are more likely to slip through the cracks in the system and not have their symptoms accurately diagnosed until a later age. We now know that the earlier in a child's life that we can accurately identify and begin treating their symptoms, the more positive the mental health and overall developmental outcomes will be (Hankin & Abela, 2005; Lyons-Ruth & Zeanah, 1993). Difficulties, that are identified early in life and are addressed through jointly focused interventions (focuses on and includes both parent and child), show the most favorable group outcomes (DelCarmen-Wiggins, 2001; Lyons-Ruth & Zeanah, 1993). It is unfortunate but there is little evidence that community-wide,

systems-based organizations exist that uniquely blends proactive identification and prevention services with well-tailored intervention components.

The Community Mental Health Center of Crawford County has envisioned such a system and their professionals have worked to create a community collaborative program that includes the features that the Minnesota Feasibility study group determined to be a necessity within a system of infant mental health care. The Minnesota State Early Intervention Team selected the University of Minnesota's Center for Early Education and Development to "conduct a Feasibility Study on an Infant Mental Health Services Framework for the State of Minnesota," (*Center for Early Education and Development, 2005*). This multidisciplinary team was put together in response to Minnesota's need's being reported by front line professionals to create a comprehensive system of services for families and their young children, and the study was commissioned Part C of the Individuals with Disabilities Education Act (IDEA). The Feasibility Study, which was completed by the University of Minnesota's Center for Education and Development, concluded that the most effective approach to address the concerns about the future of our society is to begin by creating collaborating systems of care that uniquely blends both quality physical and mental health services for young children and their families (*Center for Early Education and Development, 2005*). The feasibility study came up with the following components that the CMHCCC has worked to incorporate,

- (1) the organization or reorganization of existing services and institutional systems in an effort to meet a family's basic survival needs such as food, housing, and health care;
- (2) the facilitation of a consistent, supportive relationship with the infant and parents;
- (3) a system of ongoing screening, assessment, intervention,

and case management in order to address a range of developmental, mental health, and environmental or adjustment needs, and (4)the provision of intense support and interventions to infants and their families experiencing more serious developmental and psychosocial vulnerabilities (*Center for Early Education and Development, 2005*).

Brief Description of Methodology

For this dissertation project, I will be utilizing a qualitative approach to the completion of a formative evaluation. The qualitative approach was selected, based on its inherent design that targets the importance of gaining an in-depth understanding of each individual's unique experience and story. When completing a formative evaluation, there should be a mutual agreement between the stakeholders, the program, and the evaluator, regarding what is to be studied, how it is to be studied, and how the resulting data will be used (Rossi, Lipsey, & Freeman, 2004). For the purposes of the formative program evaluation, the stakeholders have been identified as being the directors of the two collaborating programs (the Community Mental Health Center of Crawford County Community and Early Childhood Services Southeast Kansas Community Action Program). They are the primary intended audience who will receive the evaluation findings.

With this in mind, on March 19, 2007, I had a preliminary meeting with the Clinical Director of the Community Mental Health Center of Crawford County, Michael Ehling LCMFT, and Linda Broyles, the Director of Early Childhood Services, Southeast Kansas Community Action Program (SEK-CAP). During this meeting, the agenda was to determine the goodness of fit between a formative evaluation and the major players who

carry out the targeted program, and also between the stakeholders and the evaluator. It was determined that there was a good fit. Together, we agreed to the purpose of the study and, therefore, we proceeded to discuss possible interview questions to be answered by the two program directors and their designated staff members.

Research Question

The important lessons learned by the Community Mental Health Center of Crawford County (CMHCCC), and their community collaborator (SEK-CAP), could further help inform the fields of Infant Mental Health, Marriage and Family Therapy, and Community Mental Health Centers, in order to:

1. Illuminate the process by which CMHCCC created the new approach to treating IMH concerns within the infant, their family, and the greater community context, and ask how it has been operationalized during the first two years of service delivery,
 - a. Discover the organizational and procedural barriers, through the in-depth staff interviews, to assist the CMHCCC and their partners in their continued effort to provide high quality services,
 - b. Better inform policy makers and financial decision-makers of the early signs of the positive effects of such services, and
 - c. Gather feedback on the usability of a collaborative approach to addressing IMH concerns within a collaborative community mental health center approach, which could help lead to other CMHCs replicating the model in their catchment areas.

Limitations of the study

This study is limited in its generalizability to broader populations, due to utilization of only one distinct population sector being served by one particular community mental health center. The targeted populations to receive the new services through the community collaboration, under the umbrella of the Community Mental Health Center of Crawford County, are women within the CMHCCC catchment area, who are pregnant and are currently suffering from psychiatric disorders or who have been identified as having substance abuse disorders. It is also limited by the narrow scope of the evaluation. Since this is a formative evaluation, my main focus was on the formation process and not the initial clinical outcomes, satisfaction of clinical population in services, or the impact the services are having on the prevalence statistics. There is also a retrospective nature to the interviews that took place. The program director began creating the program outline in 2003 and the interviews were conducted in 2008. By asking individuals to recall events and experiences from the past lends itself to the possibility of the participants' not accurately recalling the information.

Conclusions

There has been an increase in the number of identified young children who display early behavioral signs of mental health issues, including anxiety, depression, inability to self-regulate and self-soothe, over-aggressiveness, excessive levels of activity, disengagement, and a lack of overall curiosity (Hankin & Abela, 2005; Ollendick & Hersen, 1983). This boost is most likely due to the increased tools designed to help professionals more effectively understand what they are observing in young children, including the Diagnostic Classification of Mental Health and Developmental Disorders of

Infancy and Early Childhood (1994), and improved screening tools such as, “the (BIA) Borgess Interaction Assessment, used as a screening tool by nurses at the hospital following the birth of the child. Other screening tools include the HOME (Home Observation for Measurement of the Environment), NCAF (Nursing Child Assessment Feeding Scale), NCAT (Nursing Child Assessment Teaching Scale), NBAS (Neonatal Behavioral Assessment Scale), and the Ainsworth Strange Situation” (*Center for Early Education and Development*, 2005). There are additional screening tools now available to determine a child’s developmental progress and test for any delays that might be present, such as the Denver and the Bayley (*Center for Early Education and Development*, 2005).

There is also an increased awareness of early childhood mental health issues across professional domains, including within the field of Marriage and Family Therapy (Sved-Williams, 2003). As the awareness of early childhood mental health issues continues to grow, an increasing number of professionals will begin to more readily utilize the aforementioned tools available to them. With the increased number of tools available to professionals, working with the 0-3 population, that are designed to identify young children with mental health issues, the deficit of well-trained clinicians and systems of care to treat those increasing numbers of identified children looms large.

Definitions

Below you will find a group definitions that you will find more in-depth explanations of each of them at the beginning of chapter two. The definitions are not in alphabetical order, they are in order in which they occur in chapter two.

Infancy: Infancy is the period of life designated as covering conception to age three.

Infant Mental Health: Infant mental health is the appropriate addressing of mental health issues within the zero to three population.

Infant Mental Health Field: The field of Infant Mental Health is defined as being the multidisciplinary group of professionals committed to addressing infant mental health concerns.

Individual Risk Factors: are seen as creating increased susceptibility for mental health difficulties to occur.

Family Risk Factors: There is a bi-directional nature within family relationships and these risk factors are those that are experienced by the family and result in increased susceptibility for mental health issues to occur.

Family Protective Factors: are factors that that create a protective buffer for an infant and or family against negative mental health outcomes.

CHAPTER 2 - Literature Review

The idea of compiling a complete literature review for a topic as complex as this one, which clinically and theoretically joins the fields of infant mental health and marriage and family therapy, is a daunting one that has forced me to pare down both fields. I am going to guide the reader through four waves of information. My rationale for utilizing the analogy of waves is to help create the picture of a wave of information coming toward the reader, regarding one field of study. As the wave gets closer to the reader, the information is more narrowly focused upon how the information relates to this particular study. Then the wave goes back out to broader body of information that is away from the reader and, from there, the cycle continues to go from the broad categorization of information to a much more narrow scope.

Within the first wave, I will begin with the historical origins of infant mental health, including a number of theories that embody the field of infant mental health (IMH), the major players within those theories, and the applicable definitions for each theory. I will also include traditional clinical approaches to address the presenting infant mental health concerns.

The second wave will discuss the traditional theories within the Marriage and Family Therapy (MFT) field, including applicable definitions for each theory. Within the second wave, I will also be describing the history of MFTs working with the zero to three population, followed by the theories of most relevance. After the MFT theories have been discussed, I will then be describing the traditional MFT clinical approaches to address the most frequently presenting IMH concerns.

In the third wave of information, I will be briefly describing the history of community mental health centers and the clinical services offered historically through the community mental health center approach.

In the fourth wave, I will be building a bridge as to how a new combined theoretical and community collaborative approach is being utilized in a rural community mental health center. I will first complete a brief review of the traditional services offered through community mental health centers and then more narrowly discuss the targeted community mental health center's new approach. The new collaborative community mental health approach, to deal with IMH concerns, is located in the Midwestern United States, within a rural county in Kansas. Due to the importance of the contextual variables in the provision of any mental health service, I will be providing an explanation of the rural environment followed by a history and current description of the Community Mental Health Center of Crawford County (CMHCCC) and their community partners. This background will serve as a frame for my research.

Wave One: History of Infant Mental Health Clinical Work

Story of the field

The recent intensification of the research into infancy began during the early 1960s but, the earliest published work involving infancy was completed by Darwin when he reported his personal observations of his young son in 1845. During the early 1970's, researchers declared that infants were indeed active participants in their environments, both being influenced by their environments and influencing their environments. The bi-directional nature of this relationship between the infant and their environment has been a topic of debate ever since (Osofsky & Fitzgerald, 1999).

Definitions

Infancy

According to the World Association for Infant Mental Health (WAIMH), infancy is defined as beginning at conception and extends to age three (Hoffmann, 2002). There are a variety of definitions for the number of months and years that are included in the period of infancy. I selected this definition based on credibility of the professionals who embody the World Association for Infant Mental Health. The earliest ideas of infancy as being a specified period of time became known around the 1850's and, before that, infancy referred to school-aged children and not to the zero to three population (Fitzgerald & Barton, 2000).

Infant mental health

The national Zero to Three organization has defined infant mental health as, “the healthy social and emotional development of a child from birth to 3 years; and a growing field of research and practice devoted to the:

- promotion of healthy social and emotional development;
- prevention of mental health problems; and
- treatment of the mental health problems of very young children in the context of

their families” (*Key facts about children birth to 3 years, their families, and the child care system that serves them*, 2006).

Infant mental health field

The field of Infant Mental Health (IMH) cannot directly trace its roots back to one single professional field. Instead, the field lays claim to establishing its roots in an environment of multidisciplinary and internationalism (Osofsky & Fitzgerald, 1999).

The field of infant mental health is understood as being multidisciplinary in nature, designed especially to enhance the social and emotional competence of infants in their unique context (Zeanah, 2000). The national Zero to Three organization (2006) summed up the field of infant mental health as being:

A growing field of research and practice devoted to: (1) the promotion of healthy social and emotional development; (2) the prevention of mental health problems; and (3) the treatment of the mental health problems of very young children in the context of their families (*Key facts about children birth to 3 years, their families, and the child care system that serves them*, 2006).

IMH is embedded within a growing system of adapting and ever changing relationships that shapes and molds the social world for the infant, even before the child is born, based on the parent(s) individual and collective preparation for parenthood. The parents begin creating and living out their deep-seated expectations for their child and for their own developing parental experience, even as they prepare themselves for parenthood (Fitzgerald & Barton, 2000).

“Mental health is not just the product of a nourishing mental diet—however important this may be—but the work of a complex mental system acting upon experience, reacting to experience, adapting, storing, integrating, in a continuous effort to maintain a balance between inner needs and outer demands”(Fraiberg, 1959 p.7).

The mental diet metaphor is used to depict the regulation of what the mind takes in and how what is taken in meets the balance of the internal and external needs of the distinctive individual within their specific environment. According to Fraiberg (1959) this balance is broken down theoretically to depend upon a dynamic balance between

those internal needs of the individual personality, the basic human needs, and the requirements of society (Fraiberg, 1959).

Individual Risk Factors

There are a number of variables, or forces within the individual child, that may create increased susceptibility for mental health difficulties to occur. Such factors may include, but are not limited to, genetics, biological abnormalities of the central nervous system, developmental delays, impaired level of resiliency, negative consequences of perinatal trauma, problems in feeding and/or sleeping, premature birth, difficult temperament, and exposure to alcohol and/or other chemicals/drugs prenatally (*Center for Early Education and Development*, 2005; Hankin & Abela, 2005; Watson et al., 1999).

Family Risk Factors

Young children are dependent upon their primary caregiver(s) for the establishment of a nurturing and supportive environment, which will be conducive to appropriate development. When that type of environment is not created, young children are more susceptible to mental health issues (Stroul, 1996). It is also known that individuals grow and adapt through exchanges with h/her immediate ecosystem (the family) and more distant environments (Bronfenbrenner, 1979). When that exchange includes parents with mental illnesses, the child is at an increased risk for psychopathology (Seifer, Dickstein, Sameroff, Magee, & Hayden, 2001). Populations that experience higher rates of poverty and inadequate comprehensive health care services also will experience higher rates of diagnosable illness (Stroul, 1996). Also, research shows us that environments that contain violence also lead to increased risk of

mental health issues (*Center for Early Education and Development, 2005*). Additional family and environmental factors include, social isolation, poor parenting practices, negative family climate, chemical dependency on the part of the parent or parental figures, and/or a history of parental mental health issues (*Center for Early Education and Development, 2005; Sameroff, Seifer, & Bartko, 1997*{www.education.umn.edu/CEED, 2005 #675).

Protective Factors

There are a number of factors that create a protective buffer for an infant against negative mental health outcomes. Such factors include characteristics of parents (including high sensitivity, empathy, and developmentally appropriate expectations present for their growing infant), the presence of trusting relationship, and families' willingness to seek out and utilize available resources that are available to them (Sameroff et al., 1997; Watson et al., 1999).

Parents and families, who live within safer and more supportive community networks, are less likely to abuse or neglect their children, thus leaving the child less susceptible to mental health issues (DePanilis, Dubowitz, & Kunz, 2008). Another important protective factor can be identified as a child's having adults around h/her who are actively involved in healthy relationships with each other. Families who experience lower levels of stress also provide additional protective factors for children (DePanilis et al., 2008).

Theories of Most Relevance

According to the World Association of Infant Mental Health (2000), the field is rooted in Evolutionary, Psychoanalytic, and General Systems theories. These theories

have challenged how scientists, clinicians, and policy makers view, investigate, advocate for, and intervene on the behalf of infants and their families (Fitzgerald & Barton, 2000)

Along with these three theories, there have been other important theories and perspectives that have made a major impact on the field such as Attachment Theory and Developmental Psychopathology. I have organized these theories in the same manner that I organized the waves of information for the reader, by beginning with broader theories that informed the field as a whole and then working toward the theories that are more directly related to informing this study.

Evolutionary Theory

The Evolutionary Theory offers important insights into the adaptive nature of organisms, focusing on how an organism's adaptation influences the on-going relationship between the individual organism and the environmental context in which that organism exists (Fitzgerald & Barton, 2000). Evolutionary Theory challenged the accepted method in which infants were studied, which was to see embryological development as originating from a completed whole (Fitzgerald & Barton, 2000). "Nearly a century before Darwin and Wallace published their theories on evolution, a German zoologist (Wolff, 1733-1794) offered a novel explanation for development that he deduced from his studies of the embryological development of chickens"(Fitzgerald & Barton, 2000 p.6). Wolff proposed the idea of development as being epigenetic or developing gradually over time. This idea of an organism's gradually developing over time emphasizes the idea that each individual organism not only has the ability to adapt over time, but that they are specially designed to allow for adaptation over time. Evolutionary Theory describes how individual organisms develop throughout time, in the

relational balance between their inherent biological features and their unique environmental influences. These two factors, biology and environment, could not be studied individually without considering the other.

Psychoanalytic Theory

Psychoanalytic theory played a major role in the foundation of the infant mental health field. Sigmund Freud was an important player within the psychoanalytic field. He contributed to the early understanding of the period of infancy, especially his ideas about forming and developing personality and the emotional maturation process (Freud, 1935). With the focus being on both the forming of personality and the emotional maturation process, the field began to uncover the complex interaction between infants and the ways in which they adapted to their contextual surroundings.

Rene Spitz was also a large part of this early development with Freud. Spitz was known for his work in discovering the interactional exchange within relational dyads and the maturation of a representation of a “libidinal object” in both cognition and affect (Freud, 1935). The word libidinal refers to the basic human instincts, especially the sex drive. Freud was the first to theorize about the earliest interactions between very young children and their parents and his ideas propelled many, like Margaret Mahler and Erik Erikson, to theorize about how personality developed over time (Fitzgerald & Barton, 2000). Out of this elaboration of Freud’s early work, came the idea that individuals in early childhood need to feel safe in their environments to develop and achieve their optimal individual potential.

Rene Spitz worked with Sigmund Freud during his early investigations into the period known as infancy. He was known for his work with institutionalized children and

became known as the founder of infant psychiatry for the creation of the first “nosological classification of infant psychiatric disturbances” (Fitzgerald & Barton, 2000 p.13). Nosological classification is the branch of medicine that deals with classifying and describing known diseases (*Merriam-Webster Online Dictionary*, 2007). He was also known for his important work into emotional cues, such as the smile response (Fitzgerald & Barton, 2000).

Developmental Psychopathology Perspective

According to Mash and Dozois (2003), from the beginning of American psychiatry in 1812, there have been professionals who have believed that young children were not as susceptible to psychopathology as adults and that children were seen as being merely small adults (Ollendick & Hersen, 1983). It was not until more recent research was completed, that more widespread attention was paid to childhood psychopathology. There has been evidence found that many adult disorders have their origins in the events of early childhood (Mash & Dozois, 2003).

Due to the paucity of research, there has been a heavy debate about merely defining the terms and concepts of psychopathology in children. The importance of a developmentally sensitive approach to research, that properly incorporates contextual variables and family systems dynamics, have only recently been utilized within the last ten years (Mash & Dozois, 2003). Another problem in defining the terms is the difficulty in identifying the etiology of the issues of pathology and according to Mash and Dozois (2003), there is no one single independent cause for child psychopathology (Mash & Dozois, 2003). Most theorists, however, would agree that childhood psychopathology is a result of a number of different and frequently overlapping forces that are being exerted

upon the child, such as biology, parent-child attachment, parental approaches, availability of resources for the family and child, and a number of other environmental influences (Cicchetti & Cohen, 1995; Mash & Dozois, 2003). Bricker et al. (2004) further explains the complexity of grasping the difficulties that young children face by stating that,

Defining and determining young children's aberrant social-emotional behaviors, or mental health constructs that identify potential problems, is a complex undertaking because the form and function of children's behaviors and its interpretation is dependent upon or influenced by a constellation of at least four important variables: Developmental level and age, time and setting, individual differences, and family/cultural expectations, (p.132).

According to Cummings, Davies and Campbell (2000), "Developmental Psychopathology is not a narrow specialty, but rather, is a broadly conceptualized approach to understanding the complexities of human development" (p.17).

Developmental Psychopathology, like Infant Mental Health, is an inclusive field that seeks to be multidisciplinary in how research and practice are approached, as well as how children and families are evaluated (Cummings et al., 2000). Sameroff, Lewis, and Miller (2000) added to that definition by stating that "*developmental psychopathology is the study and prediction of maladaptive behaviors and processes over time*" (p. 3).

It is important to see why developmental psychopathology is vital to understanding infant mental health. The primary need for developmental psychopathology is that at the core of this conceptual framework is the desire to determine the very nature of normative development and developmental psychopathology (Cummings et al., 2000; Lewis & Miller, 1990). In order to comprehensively study

developmental psychopathology, this field derives insights from a diverse group of fields such as molecular biology, behavioral genetics, child psychology, psychiatry, and developmental psychology. According to Cummings et. al.(2000), developmental psychopathology separates itself from similar fields through its understanding that “developmental deviation and resulting disordered behavior is seen as developing over time from complex transactions among genetic, biological, and psychosocial processes that influence adaptation at particular developmental transition points” (p. 7). This is a departure from the more traditional medical model approach that identifies and treats a disorder as being derived from a single cause and residing within a single individual. The developmental psychopathologist is interested in how each individual and system adapts through time and how they deviate from that which is considered to be normal.

Attachment Theory

Whereas developmental psychopathology deals with all the domains of development (e.g. cognitive, language, motor, social, etc.), attachment theory focuses on social-emotional development and, specifically, the relationship of the infant to the primary caregiver and the consequences of this relationship for later development.

Two major ideas about Attachment Theory, as presented by John Bowlby (Bowlby, 1969), will be discussed in this section as an overview of Attachment Theory. The first idea is attachment theory has its foundation in a ‘motivational-behavioral control system’ that seeks a small number of familiar and preferential caregivers to promote their survival (Bowlby, 1969, 1982; Bretherton, 1985; Fraiberg, 1987), and the second idea is that individuals create internal working models of relationships (Bowlby,

1982). These internal working models are used as templates for how the individual perceives relationships' being structured and how those relationships should function.

John Bowlby was an early British pioneer who began his training in medicine before working in psychoanalysis. After he received his degree in analytic training, he continued his educational training by pursuing psychiatry (Karen, 1998).

The idea of a motivational-behavioral control system is central to the relational focus that Bowlby felt was missing from Freud's earlier theory. Bowlby introduced this idea of individuals' seeking relational security through proximity and sometimes physical contact with a preferential figure, also referred to as a secure base, when a situation is perceived as dangerous to the individual causing distress. Individuals will also seek out a preferential figure as a "playmate" when they are feeling more safe and secure (Bretherton, 1985; Slade, 2004). Bowlby (1982) discovered a special category of behaviors that he called attachment behaviors. These attachment behaviors are "any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world. It is most obvious whenever the person is frightened, fatigued, or sick, and is assuaged by comforting and caregiving" (Bowlby, 1982 p.668).

Bowlby (1982) believed that these attachment behaviors were an instinctive drive within each individual human being and this belief was a contrast to the former thoughts of such theorists as Freud, who believed that the two primary drives in humans were feeding and sex (Bowlby, 1982). Much of Bowlby's ideas of attachment behaviors were derived from the innovative work of ethnologists, such as the work of Konrad Lorenz, who studied the biological and evolutionary origins of behavior. Bowlby was keenly

aware of Lorenz's work with baby ducklings in his study of imprinting (Bowlby, 1969). This idea of imprinting or bonding identified a critical window of opportunity for young ducks to become bonded to an object early in their life. This critical period for ducklings was immediately following their hatching. The new ducklings would seek out the first moving object that they saw and soon would only follow that one moving object that they first saw (Bowlby, 1969; Hoffman, 2005). Bowlby, however, didn't agree with Lorenz's idea of a definite starting and stopping point for the imprinting or bonding process to occur. When Bowlby coined the new term of attachment, he identified attachment in humans as taking place over a longer period of time and through a process of stages (Bowlby, 1969). There is a need to clarify the definitions of bonding versus that of attachment. Bonding refers to the "bond of the mother to the newborn children that forms in the early hours or days after birth. Attachment was used by Bowlby to describe the child's developing tie to the mother, that occurs more slowly over a longer period of time during the first year of life"(http://online.ksu.edu, 2005).

In the early 1960's, Mary Ainsworth became an associate of Bowlby's and together they worked to create the theoretical framework that continues to be known as Attachment Theory (Lyons-Ruth & Zeanah, 1993). Mary Ainsworth, a Canadian psychologist, shared Bowlby's views and passions and she began researching attachment and babies and her results supported that which Bowlby had already been talking about. She created an innovative observational technique to assess attachment in babies, by observing mothers and their infants in the lab at John Hopkins University. This observational assessment technique became known as the "strange situation procedure" (Crowell & Fleischmann, 1993 p.213). This procedure focuses on the infant's response to

mother's departure and her reunion with her child. Bowlby and his colleague James Robertson, in the late 1940's, began observing patterns of distress within young children when they were without their mothers. He concluded that there could be a lot understood about pathology by observing a child prior to being separated from their mother and at the reunion with their mother (Bowlby, 1969).

Ainsworth took her observations of the babies' responses, when the mother left the room and when she returned, to categorize the attachment style of the child. It was Ainsworth who identified the first three distinct attachment styles, which are "Secure", "Insecure Ambivalent" or Resistant", and "Insecure Avoidant". "Secure attachment" typically includes children who prefer to not have their mother leave the room during a strange situation but who return to a calm state shortly after mom returns. These children are excited when mom returns to the room; they reunite with her, are relatively easily consoled by their mother, and then they return to what they were doing prior to her return (Karen, 1998). Ainsworth labeled her second group as "Insecure Ambivalent" or "Resistant". These children would respond to their mother's leaving the room by becoming anxious and agitated. When their mother returned to the room, these children would seek out contact with her but also displayed strong anger toward her and would resist being soothed by mother. The third and final attachment style is labeled as "Avoidant". These children demonstrated little need for their mother for a secure base, either while she was in the room or upon her leaving the room. These children showed little to no concern, as if they were not impacted by her departure. Upon mothers return to the room, these children would avoid mother and remain distant from her (Karen, 1998).

The second idea of Attachment Theory, according to Bowlby (1969), is that individuals create internal representations, or internal working models, of their reality, based on their early childhood experiences (Bretherton, 1985; Colin, 1996). According to Karen (1998), this idea was not new to Bowlby but it was taken from the earlier work done in the psychoanalytic camp by Melanie Klein (p. 38). Klein was one of Bowlby's supervisors at the Tavistock center in London, England. Klein and Joan Riviere (Bowlby's personal analyst) were the two figures that grounded Bowlby's thinking in Object-Relations theory (Bowlby, 1969). These internal working models are templates which each individual utilizes to assess and guide them through new situations (Slade, 2004). Bowlby described that, through his years of observations, "important relationships can influence the internal working models of relationships that we carry with us from childhood" (Harmon, 2003 p.25). These internal models are continually being revised throughout the developmental process and the rate of the revisions relies heavily on the individual's cognitive capacity and their unique ability to ascertain the intentions and motives of those within their world, especially those to whom they have a primary attachment to (Slade, 2004).

Donald Winnicott was another early pioneer in Objects Relations Theory, whose ideas greatly influenced Bowlby (Bowlby, 1969). Winnicott believed that, if children were going to develop a positive sense of self, they needed the influence of parents who were available to be used by the child as they matured (Winnicott, 1941, 1953). In his opinion, the parents needed to be accessible to the child as they experienced new things so that the parent could help develop the child's sense of security and be encouraged to explore and grow within a safe environment. If the parents are not accessible, the child's

sense of what is safe or not safe doesn't have the opportunity to become well developed and their internal working model is not intact (Winnicott, 1953). Therefore, as children enter new situations, they are more likely to be in a state of alarm rather than in a positive state of calm.

This idea of a child's utilizing his/her parents as a barometer for safety and security in new experiences became known as a holding environment (Winnicott, 1953). Winnicott's (1953) idea of a holding environment was used to describe the psychological space between mother and the child. It explained how the child utilizes the mother as a transitional object from dependency to autonomy (Bowlby, 1969). This process is further explained as the child's using the mother as a secure base to determine what is safe and what is dangerous. As the child matures and adapts to new situations, the dependency upon the mother for security declines and his or her own ability to self regulate increases. Winnicott (1941) also shared in Freud's psychoanalytic theory regarding young children's anxiety. He believed that young children use important figures around them to help them determine what their anxiety is about and what is happening with their body in response to the anxiety (Winnicott, 1941). The terms "holding environment" and "secure base" influenced Bowlby and other attachment theorists, as they continued to work to better understand the infant's development of self separate from others and how relationships with primary figures influenced that process. Bowlby utilized Winnicott's idea of a child on a journey from complete dependence to autonomy and the uniqueness for each child in that journey to further develop his or her attachment phases (Bowlby, 1969; Winnicott, 1965).

Bowlby (1969) reported that attachment occurred in four phases and the progression through each phase was dependent upon the child's individual maturation process. The first phase was the *Preattachment* phase (birth to eight weeks), which included such attachment behaviors as crying and smiling to provoke caretaking behaviors. During this phase, the child does not differentiate between caregivers. The second phase is called the *Attachment-in-the-making* phase (eight weeks to eight months). This phase includes the child's developing a sense of preference for a particular caregiver but there is no protest when that caregiver is not present. The third phase is called the *Clear-cut attachment* phase (eight months to eighteen months). During this phase, the child begins showing preference to a primary caregiver and displays fear in the presence of strangers. The fourth and final phase is called *Formation of a reciprocal relationship* (eighteen months and beyond). During this phase, the child utilizes his or her new language skills to protest separation from the primary caregiver but these protests occur less frequently than in the *Clear-cut attachment* phase, due to the child's ability to understand that when their primary caregiver leaves that they will return. The child is also gaining their independence during this stage. Their language skills are also used to interact with their primary caregiver and others in relationships (Bowlby, 1969).

Summary of Theories

These theories, which have been outlined above, have challenged the manner in which infants and families have been examined and understood through time and are the fundamental theories of change in this field. Although these theories have been vehicles for change, the front line clinicians have required clinical tools and interventions to fully become the agents of change for which the theorist would have hoped. Evolutionary

theory fostered an understanding of organism's adaptive abilities and focused on the relational balance between inherent biological and environmental forces at work on the organism as it adapts over time.

The Psychoanalytic Theory contributed a great deal of understanding to the field of IMH through their work on personality development and the emotional maturation process. Out of the Psychoanalytic, came also the first nosological classification of infant psychiatric disturbances. The developmental psychopathology perspective contributed a great deal to the understanding of normal development and a better understanding to process of deviation from that which is considered normative.

Developmental psychopathology also clarified causation as being the result of a number of different and frequently overlapping forces that are being exerted upon the child, such as biology, parent-child attachment, parental approaches, availability of resources for the family and child, and a number of other environmental influences. The Attachment Theory contributed a great deal to the understanding of the social-emotional development of individuals and how that development influences later development. The Attachment Theory is credited for supplying knowledge about the innate internal drive for individuals to be in connection with a few primary figures in their life and also the establishment of phases for the attachment process. The Object Relations Theory contributed and understanding to the Attachment Theory the idea of there being internal working models by which individuals use as templates to approach new situations. These internal working models are dynamic in nature and are constantly being influenced and updated through an individual's relationships with important figures in their life.

It is critical for the field of IMH to clearly delineate the core terms of the field and work toward creating a common understanding of the early warning signs in children. This is crucial in order to better educate professionals on how to identify and effectively treat the early difficulties within individuals and the larger systems in which they live.

Traditional Clinical Approaches to address IMH Concerns

Parent-Child Psychotherapy

The development of young children, along with their internal world, have both been researched to determine how best to clinically conceptualize their needs and to provide treatment for those needs (Lieberman, 1992). The most frequent presenting clinical issues, for the infant population, revolve around difficulties in sleeping, feeding, in the relationship between caregiver and child, and maturational issues (Harmon, 2003; Sved-Williams, 2003).

Having young children physically present in the therapy room allows for fewer obstructions to clearly receiving the client system's narrative presentation of the problem (i.e., therapist misunderstanding the presenting issues, allowing report bias to color the intensity of the problem, and decreasing the therapist's misattributing of the difficulty being presented) (Lieberman, 1992). It is important to observe the parental responses to the child as potential representations of parental projections onto the child (Lieberman, 1992). The primary focus of the infant mental health assessment is the relationship interaction within three primary interactions: between caregiver and infant, between infant and interviewer, and parent and interviewer (Hirshberg, 1993).

Observing parent-child relationship patterns is a vital component of Selma Fraiberg's approach to intervention, which is called the Fraiberg Intervention Model (Fraiberg, 1987). Fraiberg's model went further to include kitchen table therapy through home visits, not just seeing parents and babies together in a clinic. Selma Fraiberg began her early clinical work with handicapped infants, mainly blind children, and their families. Her work enlightened the world as to how the developmental process can be inhibited by both environmental and congenital factors (Fraiberg, 1987). She developed the Fraiberg Intervention Model, which she developed as a worker-oriented approach that is based in an optimistic developmental view of the child and his or her family. This approach also worked to help the parents identify their expectations, both conscious and subconscious, for their child. These expectations are known as their "ghosts", which represent the internalized objects from the parent's past (Fraiberg, 1987). These internal objects from the parent's past are things like, abuse from the parent's early childhood being revisited upon their young child. The parent's own experiences, from early childhood, shape their expectations for their child. Understanding their expectations, helps the parents properly assess their own traumatic pasts and to better understand how their expectations are influencing their relationship with their child.

Selma Fraiberg (1959) stated that the internal world of young children is mysterious in the way that it shapes his or her interactions and relationships with the outside world. Knowing the predictable stages of normal development and what capacity each stage allows the child, parents and professionals are able to access and assist the child in continuing to develop and adapt to the environment around them (Fraiberg, 1959). The idea of a mental diet was created by Fraiberg to assist professionals and

parents alike, to be able to understand that a proper mental diet does not, in and of itself, create mental health. Mental health, according to Fraiberg (1959), also depends on the appropriate contextual variables' interacting with and balancing with the internal needs of the individual child. This is the unique balance that Fraiberg (1959) addressed in her work the "Magic Years" that created a solid foundation for the understanding of the interchange between the internal needs of the unique child, how that child interacts with his or her environment, and how the environment influences the inner life of the child (Fraiberg, 1959).

According to Deborah Weatherston (2000), the practice of IMH was created when Fraiberg, and other professionals working with her in the early 1970s, began recognizing the importance of the first three years of life (Weatherston, 2000). Selma Fraiberg, in the 1970s, created parent-infant psychotherapy when there was very little awareness of the unique influences that the infant contributed to the relationship difficulties between parent and child. Lieberman (1992), who was a student of Fraiberg's, claimed that it is during the first year of life that the child is the most subject to the parents' projections. This applies for both healthy and harmful projections. To enrich the clinical understanding of a case involving infants, Lieberman (1992) suggests that the current literature and research is becoming more focused on the infants' influence on the parent, rather than just on how parents influence and shape their children.

It is also beneficial for the therapist to have several opportunities to observe the developmental aspects of the child, such as the child's ability to self soothe, ability to regulate mood, the range of social signals utilized, and the child's physical activity (Lieberman, 1992). This is part of a traditional developmental guidance approach to help

guide and support the parent. During this observational time, the therapist is building a strong working alliance with all family members by being supportive, non-critical, and appropriately using humor to frame or reframe less desirable characteristics of the child. Lieberman (1992) suggests this allows the family to connect more easily with the therapist because the therapist demonstrates a more complete understanding of their child. While Lieberman's focus was primarily on the first year of life, she theorized that the first year of life set the foundation for the second year's development. The second year of life focused on the development of a child's global abilities (speech, physical activity, complexity of emotions, and the expression of those emotions), which leads the therapist into the rich observation of the parental response to the child's transitioning behavior, abilities, deficiencies, and how the two partners uniquely influence the interplay in their relationship (Lieberman, 1992). The first year of life is essential time period for Lieberman's approach to parent-child psychotherapy due to the fact that during the first year of life the child represents a more accurate representation of their parents' projections (Lieberman, 1992).

Lieberman (1992) reports that projective identification is vitally important to observe in order to better understand the inner workings of the relationship between the parent and the child. She suggests that this process is continually being altered. Projective identification is when images of certain internal objects are projected onto other family members, who are then induced to act out these projections (Nichols & Schwartz, 1998).

Lieberman (1992) reports that projective identification occurs in three phases:

Phase One: Projection

This occurs primarily when the parent projects onto the child. An example of this phase would be how a mother feels overwhelmed by the needs of her three-month-old son and begins to label him as being needy, as overly manipulative, or as a controlling male.

Phase Two: Pressure to comply

Continuing with the above example, the mother begins to pressure her son to behave how she has represented him. The son begins to cry out for a diaper change at an inconvenient time and she delays changing the soiled diaper, angrily stating that he is not going to control her like he always does.

Phase Three: Identification

The son begins to accept his mother's expectation of him as being a controlling and manipulating male and so he begins to act out as she has suggested. The longer this projective identification process continues to be apart of the interpersonal life of the child, the stronger the internalizations will become. As the process carries on, it makes it more difficult, if not impossible to work clinically to overturn those deeply seated internalizations. It is possible to assist the parent in becoming more empathic and better able to identify with the child's experience, thereby, helping to create a more secure attachment relationship (Lieberman, 1992; Nichols & Schwartz, 1998).

Lieberman (1992) believes that it is clinically important to work toward reducing existing pathology and creating preventative features for the future. To accomplish this healthy change, therapists need to understand the parental distortions, clarify them, and work to correct them. In order to address these distortions, the therapist should be aware of the developmental capacity of the child and intervene accordingly. This can be

understood as directly speaking of parental distortions in front of a three month old and not directly addressing the same issues in front of a two year old. The three month old does not have the ability to comprehend the language at that age and it may cause more stress to remove the mother from the infant to speak directly to the parents about the distortions. The two-year-old has a greater capacity, developmentally, to take on the parental distortions and begin to internalize them. Therefore, the therapist should not speak of the parental distortions in front of the two-year-old.

Lieberman (1992) does not suggest intervening immediately when relational difficulties occur during sessions. This interaction presents a wonderful opportunity to see the family at their most normalized state and gives great insight into what happens outside of the therapy room in the client system's everyday world. Therapeutically, there can be guidance once the process of the interaction is better understood. If there is imminent danger to the child, the therapist should step in to protect the child and more directly instruct/guide the parent(s). The more the family, as a whole, is understood by the therapist during these interactions, the more tailored the interventions or guidance can become to create the best fit for the entire unique family system.

It should be noted that Lieberman's parent-child psychotherapy is designed to have the parent and child meet with a psychotherapist once a week, for a duration of anywhere between a few months up to two years, mostly in the family's home but can also take place in a center, for up to ninety minutes per session (Juffer, Bakermans-Kranenburg, & IJzendoorn, 2007).

Watch, Wait, and Wonder

The Watch, Wait and Wonder (WWW) approach is a psychodynamic parent-infant psychotherapy program that is unique to other approaches in that it sees infants themselves as patients and as an essential member of the treatment process (Lojkasek et al., 1994). Therefore, the infant's initiatives are vital for the clinician and mother to follow in a way very similar to the way clinicians participate with older children in play therapy (Cohen, Lojkasek, Muir, Muir, & Parker, 2002). It should be noted that this intervention is consistent with the principles found in the attachment theory. "In WWW both mother and infant were given the opportunity to work out their relational struggles more directly" (Cohen et al., 2002 p.365). By working through those relational struggles early, there is a greater potential for changing the intergenerational attachment patterns and creating a more secure attachment relationship. This therapy approach is suggested to begin around four to six months of age and averages 14 sessions over five months of time. The WWW approach is completed inside of a specialized treatment room that is designed with the infant primarily in mind (Cohan, Lojkasek, & Muir, 2002-2003).

It has been suggested that it is crucial for the therapist to facilitate an environment in which emotional curiosity is encouraged and emotional identification and adaptation are explored. The earlier in the life of a child this begins, the healthier the developmental trajectory will be (Lojkasek et al., 1994). Even though the evidence is unclear as to the best manner in which to accomplish the healthiest developmental trajectory, it is evident that well-tailored interventions can be effective in attaining the desired goals of quality attachment relationships, the infant's appropriate socio-emotional development, and healthier family system functioning (Lojkasek et al., 1994).

Interactional Guidance

The interactional approach, according to Susan McDonough (1993), “is an approach to the treatment of parent-child relationship disturbances...created specifically to meet the needs of infants and their families who had not been engaged successfully in previous treatment or who had refused treatment referral” (McDonough, 1993 p.414). This approach is designed to be brief and family problem focused. The families, with whom this approach has been utilized, could be considered multi-risk or at-risk families who struggle with a number of overlapping stressors, such as poverty, transportation difficulties, inadequate social support, and a higher risk of substance use, just to name a few (McDonough, 1993).

Interactional Guidance utilizes videotaped sessions of family interactions to be reviewed through a strengths-focused lens, to point out the strengths of the family interactions in order to build a more positive regard for the child and for the parent-child relationship (McDonough, 1993). Videotaping the family interaction gives the clinician significant structural and relational information that helps the clinician work with the family boundaries, roles, and relationships.

The videotaping is done for a portion of the session to catch the play interactions of the parental unit with the child. Then the videotape is played back and reviewed with the family. This allows the clinician to point out strengths to the family system, obtain additional information from the family members, and allow the family to observe themselves in action throughout time. This provides an exceptional growth-monitoring process for the family and the clinician, from the beginning of therapy right up to the final session. It is important to understand that the clinician takes on the position of information gatherer, as to allow the client family systems to best explain their identified

struggle, so the clinician can address their specific concerns. The clinician views the information, gathered through a lens, which depicts the parents as doing the best job that they can do and that fosters a partnership with the family to resolve their identified issue(s) (McDonough, 1993).

Unlike the parent-child psychotherapy, Interactional Guidance does not require the same emphasis on the parent's capacity for insight. Therefore, this approach can potentially be used with a larger population, including parents' suffering from such things as mental health issues and intellectual limitations. It should also be noted that Interactional Guidance can be a center-based or a home-based treatment option (McDonough, 1993).

Circle of Security

The Circle of Security intervention protocol was created by utilizing both the Attachment and Objects Relations Theories to best work to positively alter the developmental trajectory of attachment relationship between the primary caregiver and the child (Berlin, Ziv, Amaya-Jackson, & Greenberg, 2005). "The core constructs for the assessment and intervention protocol are Ainsworth's ideas of a Secure Base and a Haven of Safety (Marvin, Cooper, Hoffman, & Powell, 2002 p.109). This particular approach may be less known by the reader, so I am going to spend more time describing this intervention protocol than the previously mentioned approaches.

This 20-week intervention protocol is well supported and driven by research. During the first two group sessions, with six at-risk caregivers, either mothers or fathers, and a trusting relationship between the therapist and the individual group members is fostered. During this time, the therapist is also helping the members of the group to

understand the concepts of Attachment Theory. This helps the participants become more aware of their own early experiences, encourage the parents to become more sensitive to their child's attachment behaviors, and improve their responses to the child's attachment cues (Marvin et al., 2002).

In the following sessions, during weeks three through eight, the therapist designates one parent-child dyad to discuss their videotaped interaction in front of the rest of the group. The parents are presented with one particular lesson from the videotape to take home with them to continue to work on. During the sessions, the therapist and the rest of the group review how the parent responds to the child's attempts to explore their environment and their attempts to be soothed by the parent. These relational interactions are analyzed to determine if the parents are more comfortable with the child's exploration or their child's pursuit of comfort and safety from the parent. The parent's level of comfort then is categorized as being "over-used strengths or under-used capacities" (Marvin et al., 2002 p.117). According to Marvin et al., (2002) every parent feels more comfortable meeting the needs of his or her child in one of two areas: their child's exploration needs or their child's attachment needs. It should be noted that this approach emphasizes the need for the parent to work to meet both of these areas of needs by continually emphasizing the area that presents greater discomfort for them. This language clearly emphasizes a strengths based, non-pathologizing approach.

During week nine, the group reviews the attachment theory. The therapist seeks to point out the normalcy of the struggles that were observed during the videotape review sessions. Parents are supported and encouraged to share "insights into their defensive

process and to begin exploring how these defenses may impact their particular caregiving strategy” (Marvin et al., 2002 p.118).

In weeks ten through fifteen there is a return to videotape reviews that focus, more specifically, on the “under-used strengths and the points of struggle” (Marvin et al., 2002 p.118). At the conclusion of each of these sessions, the parent whose video was reviewed is given a picture of their doing something successfully to give them continued encouragement throughout the week. During weeks sixteen through nineteen, the parent’s review their recently videotaped modified strange situation, to be used by the therapist to continue to point out the parents’ increasing success in the areas of under-used capacities. The twentieth week is used as a time of celebration for the families to emphasize the parents’ hard work and successes. The final session is followed by a post-intervention assessment for further research purposes.

The Circle of Security intervention is designed to positively impact the attachment relationship, between parent and child, by utilizing a blending of the Attachment Theory and the Objects Relations Theory. This 20-week intervention process is highlighted by the usage of research driven treatment groups for at-risk caregivers, in which the therapist develops a trusting relationship with participants and works to encourage the caregivers to become more in tune with their child’s attachment behaviors. The therapist video tapes participants and then celebrates with the participants over their successes. The therapist takes both a coaching and educating role with the participants, through a strength-based approach.

Video-feedback Intervention to Promote Positive Parenting

One of the newest intervention approaches is the Video-feedback Intervention to promote Positive Parenting (VIPP) (Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2007). The VIPP approach is “one of the few evidenced-based parenting intervention protocols to date” (Juffer et al., 2007 Preface). This approach focuses on increasing parental sensitivity, which is the parent’s ability to read the child’s cues and having the ability respond to those cues in a timely manner to meet the child’s need appropriately (Juffer et al., 2007). This approach most closely resembles the Interactional Guidance method through its utilization of video taped interactions of the family that are then reviewed by the therapist with the family (Juffer et al., 2007). Unlike the Interactional Guidance approach which can begin really at any age, the VIPP is designed to be initiated at a specific age, which is at six months of age (Juffer et al., 2007). “*The VIPP programs are home based and short-term: The interventions are implemented in the home of the family in a modest number of sessions (usually four to eight)*” (Juffer et al., 2007 p.12). These sessions are customized to each individual family rather than performed in a group setting (Juffer et al., 2007).

These sessions, each lasting between ten and thirty minutes, are designed to capture parental responses to their infant’s cues during normal daily activities. This approach relies upon the intervener to maintain a nonintrusive approach, so as to not alter normal interactions between parent and child and also not to taint the emotional expressiveness of either parent or child (Juffer et al., 2007). The intervener utilizes a strengths based lens to capture the parent’s positive interactions and then overtly encourages the parent to continue such interactions by showing the interactions on the videotape. This improves the parent’s confidence and their overall competence. Through

the parent learning to become more attune with their child, the child then learns to trust their parent, knowing that when they express their needs their parent will properly meet those needs (Juffer et al., 2007). The themes for each session are lined out for the first four sessions as follows, “Session one: Exploration versus attachment behavior; session two: Speaking for the child; session three: Sensitivity chain; session four: Sharing emotions” (Juffer et al., 2007 p.16).

Theraplay

The Theraplay approach is less well-known treatment approach and therefore I will spend some additional time describing it. Theraplay believes that in order to address parent-child issues, there has to be a reduction of the negative impact of the disturbed cycle of interaction between parent and child. To do this, Theraplay works to create a more positive relationship between the two. In order to accomplish this, the Theraplay approach believes:

Because the roots of development of the self, of self-esteem and trust lie in the early years, it is essential to return to the stage at which the child's emotional development was derailed and provide the experience, which can restart the healthy cycle of interaction. Activities are geared to the child's current emotional level rather than to chronological age. Parents are encouraged to respond empathically to their child's needs. The goal of treatment is to change the inner representation of the self and others from a negative to a more positive one (*What is TheraPlay*, 2008).

The Theraplay website, and the related literature, doesn't specify that this approach can be used for the 0-3 population, so I contacted the Theraplay Institute in

Wilmette, IL and asked them about using Theraplay for the 0-3 population. I received a return phone from Dafna Lender, Training Director at the Theraplay Institute. She informed me that Theraplay could be used for all populations, as soon as the problem is identified, including the 0-3 population, up to age 11. (Lender, personal communication, May 29, 2008).

The Theraplay approach typically includes between 12 to 20 sessions, depending on the extent of the need being presented. The scheduled sessions are structured as follows:

The first session is an information-gathering interview with the parents. The second and third appointments are observation sessions using the Marschak Interaction Method (MIM), in which the child and one parent at each session perform a series of interactive tasks together. The interactions are videotaped and later analyzed by the therapist(s) in preparation for a fourth session with the parents. In that session the therapist(s) and parents discuss their observations of the interaction and together agree on a plan for treatment. Sessions five through fifteen involve direct Theraplay with the family, duplicating (regardless of age) the kind of playful behavior and fun games which parents and young children naturally engage in together. The interaction includes structuring, engaging, nurturing and challenging activities in combinations geared to the specific needs and problems of the individual child and his/her family. The final session ends with a good-bye party. Four follow-up sessions are scheduled at quarterly intervals, with parents and child, over the next twelve months (*What is TheraPlay*, 2008).

Summary of IMH Clinical Approaches

The above-mentioned approaches begin with the parent-child psychotherapy approach. This approach focuses primarily on the interactional relationship of the primary care-giver and the child. In order to best do this, Fraiberg (1959) introduced the idea of mental health as being a delicate balance of contextual variables and the internal needs of the unique individual. This idea contributed a great deal of understanding as to how clinical interventions were to be approached. Lieberman also added a three-phase approach to addressing parental projections: 1) help identify parental distortions, 2) clarify them, and 3) then work to correct them. The parent and child meet with a therapist weekly to reduce existing pathology and to create relational strategies to be able to work through future issues.

The Watch, Wait and Wonder approach is an infant-led intervention that takes place in a specialized treatment room, where the therapist partners with the family system to interrupt disruptive attachment patterns and work toward the creation of healthier patterns. The earlier in the developmental process this treatment begins, the better the results will be for the entire family system, especially the infant.

The Interactional Guidance approach is most frequently used for at-risk or multi-risk families, due to its short-term, family problem focused approach. It also does not require the family system to have the same level of insight as the parent-child psychotherapies. During clinical sessions, videotaping is done so that the therapist can play back the tape for the family for reviewing family interactions through a strengths-focused lens.

The Circle of Security approach is a 20 week group approach that is designed to help the participants become more aware of their own early experiences, encourage the parents to become more sensitive to their child's attachment behaviors, and improve their responses to the child's attachment cues. During the sessions, videotaping is utilized to allow dyads to learn about their growth areas and have their strengths pointed out.

The Video-feedback Intervention to Promote Positive Parenting (VIPPP) is an intervention that works through home-based, short-term session (4-8 sessions) that last anywhere from ten to thirty minutes long. These intervention sessions are customized to each family in a manner that allows for the intervener to review videotaped interactions of the normal daily interactions of the family and then facilitates dialogue with the parents to increase their sensitivity to their child's cues.

The Theraplay approach also utilizes videotaped reviews of parent-child interactions in order to reduce the negative impact of the disturbed cycle of parent-child interactions. These sessions are apart of a 12 to 20 session curriculum and involve the same overarching structure regardless of the age of participants and each session tailors interactions based on the unique age of the child.

Comparison between Infant-Parent Psychotherapy and Interactional Guidance

Therapy Interventions:

According to one research project in Geneva, Switzerland, there were significant improvements made in both the Interactional Guidance test group and the test group that utilized infant-parent psychotherapy (Robert-Tissot, Cramer, Stern, Rusconi Serpa, Bachmann, Palacio-Espasa, De Muralt, Berney, Mendiguren, 1996) The researchers found that mother-infant psychotherapies were more effective in addressing cases of

early functional disorders and the group utilizing Interactional Guidance resulted in more significant changes in the mother's sensitivity (Robert-Tissot et al., 1996). Parental sensitivity is a way to determine a parent's ability to properly identify and respond to each child's unique cues (Juffer et al., 2007).

In infant-parent psychotherapy, "The primary focus involves the uncovering of unconscious links between the parent's psychological conflicts and her parenting behaviors that are mistuned to the child's needs and interfere with his or her development," (Juffer et al., 2007 p.54). Child-parent psychotherapies empower the therapist to use his or her own judgment to guide which clinical issue is to be the primary focus of the therapy and this focus is called 'ports of entry' (Juffer et al., 2007 p.54).

In the Interactional Guidance approach, the relationship between the parent and the child is of primary importance, especially the interactions that can be utilized to support positive parenting practices through higher levels of parental sensitivity. Sensitivity, as it is used by this approach, is defined as the parent's ability to read the child's behaviors and signals correctly (Juffer et al., 2007).

Even though these two approaches differ in their ports of entry, Daniel Stern (1995), argues that it doesn't matter which approach was utilized, because they are both effective. The argument is based on Stern's view that, regardless of the target or the port of entry, if you changed one part of the system, the other would adjust and adapt (Stern, 1995).

Promotional/Prevention Approaches

Parents as Teachers

Parents as Teachers would be considered a parent training/education program, which was created in Missouri in the early 1970's. This program was designed to address the important role parents play in preparing their children to learn when they arrive in kindergarten. The kindergarten educators are also beneficiaries of the Parents as Teachers initiative as well because the children arrive at school with comparable levels of school readiness. Parents As Teachers is facilitated by trained parent educators, who, on a monthly basis, visit the family in their own home environment. While the parent educators are in the families' homes, the educator helps the families through a well-structured curriculum designed to evaluate the child's developmental capacity, to equip parents to help their child be prepared to successfully transition into the school environment, and to help families develop their child cognitively, emotionally, and socially. The parent educators work empathically with families to build a strong, working relationship with the family members, so as to consult, model, and coach help parenting practices (*Parents As Teachers*, 2007). At each home visit, the parent educator has five basic areas that are to be addressed each visit. Those five areas are as follows:

Rapport-building; observation of the whole child, considering each domain of development; *discussion*: reviewing previous visits, address parents comments and concerns, appropriate development characteristics for each child, hearing issues, grasping and mouthing activities, gross motor development, feeding issues and immunization progress. The educators also have at least one *parent-child activity*: informing the parent(s) about the rationale for the activity, coaching and modeling throughout the activity, also the activity includes a book sharing time, parent follow-up activity, and a time for shared observation. The final section of

each home visit includes a summary time. During this time, key observations are pointed out and reviewed, as well as the parent's strengths. Then the educator discusses resources and/or referrals if necessary as well as group meetings/community activities and events, and then they schedule together their next home visit time (B. Hubener, personal communication, 2007).

This program also works to identify the early warning signs of developmental difficulties. Parent Educators are all appropriately trained to facilitate and interpret several nationally researched screening tools, such as the Denver II, which measures four primary developmental areas 1) personal social, 2) fine motor, 3) language, and 4) gross motor (*Parents As Teachers*, 2007). These screening tools are completed during in-home visits and the educator interprets the information from the screenings so that the child and their family can be referred to the appropriate helping professionals to address the concerns in a timely manner. The screens are given to children at age appropriate developmental points throughout their first three years of life, so as to track the child's developmental progress and to catch the early warning signs of difficulties (*Parents As Teachers*, 2007). I was personally a consultant to a Parents As Teachers program in 2005-2006 and saw, first hand, the importance of parent educators' implementing screening tools and how this helped both the child and his or her family.

Early Head Start

According to the Early Head Start Almanac (2004), the Head Start Act was reauthorized in 1994 and Early Head Start was then created "to provide services to low-income families with children from birth to age three and to pregnant women" (*Administration for Children and Families*, 2006). Head Start was created in 1966 to

address the needs of those families that were being discriminated against because of their social-economic status. These low-income families were provided opportunities for the parents to become advocates for their families through educational opportunities that were previously not available to them. There was a strong educational component, to the Head Start Program, which connected available information in a manner in which the parents could access the learning. Prior to the Head Start Program, these types of services were inaccessible, due to lack of availability, educational, and language barriers. Both Head Start and Early Head Start would be considered family resource and support programs. Whereas Parents As Teachers is open to anyone to participate, Early Head Start and Head Start are restricted programs to those who meet the economic entry criteria.

The cornerstones of the Early Head Start Program, as related to direct services, are child and family development. The child development services include:

Early education services in a range of developmentally appropriate settings; Home-visits, especially for families with newborns; Parent education and parent-child activities; Comprehensive health and mental health services; and High quality child care services, provided directly or in collaboration with community child care providers (*Early Head Start National Resource Center, 2007*).

The family development services include:

Child development information; Comprehensive health and mental health services, including smoking cessation and substance abuse treatment; Adult education, literacy, and job skills training to facilitate family self-sufficiency; Assistance in obtaining income support, safe housing, or emergency cash; and Transportation to program services (*Early Head Start National Resource Center, 2007*).

The mental health aspect of this program is fundamentally embedded within this program's vision for children's social competence to be developed (Knitzer, 2004). Social competence is defined as being "the child's everyday effectiveness in dealing with his or her present environment and later responsibilities in school and life" (Knitzer, 2004 p.179). As a part of achieving social competence, Early Head Start enveloped social competence within five main objectives, which are to:

Enhance children's healthy growth and development and to strengthen families as the primary nurturers of their children—have explicit mental health implications. The other three objectives are instrumental: to provide children with educational, health, and nutritional services; and to ensure well-managed programs that involve parents in decision making (Knitzer, 2004 p.180).

This doesn't specifically mention any language about a direct connection to the child's mental health, but we know that, in order for a child to develop a quality level of mental health, he or she needs to have assistance in achieving healthy developmental milestones (Knitzer, 2004; Mercer, 1998). These milestones are best met through the context of nurturing families participating in the process. According to Mercer (1998),

“physical growth, health, and nutrition are the foundation of all other aspects of infant development” (Mercer, 1998 p.138). Therefore, children must have good physical health in order to have the best opportunity to obtain and maintain mental health (Zeanah, 1993).

Summary of Promotion/Prevention Approaches

Parents As Teachers is primarily a home-based program that is designed to help develop parental skills through an encouraging partnership between the parents and the parent educator. The program works to identify early warning signs of developmental difficulties through the use of multiple screening tools. This program also facilitates playgroups and educational events in which the families participate. This provides additional opportunities for parent educators to interact with families and further coach and encourage positive parenting practices.

Early Head Start is primarily a home-based program that was created specifically for those families that meet the economic criteria, whereas Parents As Teachers is open to anyone within geographic boundaries. Early Head Start was designed with a heavy educational component to meet the families where they are educationally. Early Head Start works to develop social competencies within children and their families and to meet the physical needs of the family as a system and to promote and advocate for the mental health of children.

Wave Two: Marriage and Family Therapy’s history of working with zero to three population

Families with young children frequently show signs of individual and family system distress in their adjustment to the new challenges of rearing children. Families, with children within the zero to three age group, present most frequently for professional help around issues of feeding, sleeping, and concerns about development (Mackenzie, 2003). Traditional treatment for these issues has been more medically based treatment with the family's primary care physician or pediatrician. When these issues have arisen for marriage and family therapists, children typically are excluded from the therapeutic process and the treatment has focused only indirectly on the children, through the therapist's support and guidance of the parents (Lund et al., 2002).

The field of Marriage and Family Therapy (MFT) has been on the leading edge in the study of family systems and in the creation of clinical models that focus on and maintain an emphasis tailored to incorporate the unique influences and contributions made by each member of a family system. Theorists and practitioners within the MFT community may desire to achieve the complete inclusion of all the members of a family system but the effective inclusion of the youngest members of the family system has been the exception, rather than the rule (Sved-Williams, 2003). Family therapists have a clear understanding of systemic theories and MFTs do have the necessary skills to be highly effective within the field of Infant Mental Health (IMH). Family therapy models and interventions, especially those that recognize and seek to enhance secure attachment patterns and relationships, have a natural overlap with the IMH field (Sved-Williams, 2003).

Some of the most notable theorists and practitioners in the field of family therapy have strongly advocated for the full inclusion of all family members, including children,

into family therapy sessions (Lund et al., 2002; Miller & McLeod, 2001). These early pioneers in the MFT include Ackerman, Satir, Whitaker, and Minuchin (Lund et al., 2002; Miller & McLeod, 2001). Whitaker has been known to cancel appointments with families who didn't think that it would be wise to bring children to therapy (Miller & McLeod, 2001). There is also the well known opinion of Ackerman (1970) who believed that, "without engaging the children in a meaningful interchange across the generations, there could be no family therapy" (Miller & McLeod, 2001 p.376).

There has been an effort to determine the significance of young children's participation in the therapy process and the attitudes that marriage and family therapists have about young children's participation in therapy. Korner and Brown (1990) did a research project on the inclusion of children in therapy and found that, out of 173 family therapists surveyed, approximately 86% of respondents excluded children in therapy more than 75% of the time. Korner and Brown (1990) also found the exclusion of children from therapy was highly correlated with the therapists' perception of their own competence as a result of their training experiences in coursework and supervision. According to the Korner & Brown (1990) study, there was a correlation between respondents (who were all marriage and family therapists), who had received special course work and/or supervision in working with children, and those that responded by stating that their client loads consisted of higher numbers of children as clients. They went on to conclude that approximately 40 percent of the surveyed therapists never included children in the treatment process (Korner and Brown, 1990). This study reveals that, when therapists feel that they have sufficient training in working with children, they are more inclined to work with more children as clients. According to their findings, the

therapists' comfort level with working with children is one of the strongest determinants for the inclusion of children in the therapeutic process. Also, this research indicated that as a field, MFTs need additional specialized training in working with children (child development, developmental psychology and psychopathology, child assessments, and child psychotherapy) in order to put the 'family' back into marriage and family therapy (Korner & Brown, 1990).

When looking into how much of the MFT literature covers the inclusion of children, Lund and colleagues (2002) found "a total of 64 publications (40 journal articles and 24 book chapters), published between 1970 and 1999...eleven of the publications were written in the 1970's, 14 in the 1980's, and 39 in the 1990's" (Lund et al., 2002 p.446). It would be far too difficult to discover and evaluate all the literature on this particular topic, but according to Lund et al. (2002) this is a sufficient sample to properly identify the trends of MFT for including children in therapy. It should be noted that approximately 67% of the professional articles found, included preschoolers within them (Lund et al., 2002). Lund et al. (2002) found that one third of the professional articles discussed the inclusion of infants in the therapy process.

In its brief 60 year history, the field of MFT has been rooted in strivings for innovation and a competitive drive within the field, and between theorists, to prove that one model is the best fit for any particular presenting issue or clinical situation (Sprenkle & Blow, 2004). As Sprenkle and Blow (2004) alluded to, when competition creates an environment that does not promote the acknowledgment or acceptance of the value of other approaches, the optimum level of care can not be provided to client systems.

Theories of most relevance

General Systems Theory

Between 1928-1934, Ludwig von Bertalanffy took his model of organismic biology and began making alternative suggestions to the already present linear models of development within the science field. His alternative eventually became known as General Systems Theory (GST) (Von Bertalanffy, 1972). Von Bertalanffy's GST accentuated the importance of understanding all living systems as being open to the influence of information flowing into and out of each system. GST further explained the importance of the interaction between parts that make up the greater whole, rather than just focusing on how these subparts contribute individually to the greater whole (Von Bertalanffy, 1972). He hypothesized that the individualist influence should not be considered to be simply an automatic and mechanical cause-effect relationship but, rather, as a system of people and individuals, creating meaning for interactions and relationships. It is this interaction that creates the actions and reactions within the system (Nichols & Schwartz, 1998; Piercy, Sprenkle, & Wetchler, 1996). This allows for a clearer understanding of family dynamics and the bi-directional influence between the parents and infants, rather than simply looking at the family as being made up of different subsystems. GST allows for a clearer understanding of how the subsystems uniquely influence other systems and how that impacts the developmental outcomes of all the members of the entire system. This was further explored by Walter Buckley (1968) and other systems theorists, who explained the "interconnectedness and mutual causality of human systems" (Piercy et al., 1996 p.3).

This idea of interconnectedness and mutual causality was intended to depict the nature of overlapping systems and subsystems, continually interacting and influencing each other. These living systems exist within an environment that both influences and accepts influence from the living systems. Fauchier & Margolin (2004) added that the underpinnings of the family systems theories include the idea that subsystems, within the larger family system, have a bi-directional influence on each other (Fauchier & Margolin, 2004).

The greatest impact that GST has had on infant mental health has been its influence on how the process of development was conceptualized (Fitzgerald & Barton, 2000). The development was no longer seen as linear but rather as being a circular and ever-changing process. A theorist must first become aware of each individual's distinctive characteristics and then each dyad, before he/she can even begin to seek to more fully understand the complexities of each family system and how that system distinctly functions within their unique environment. Systems theory also provided a much needed conceptual framework to further study systems and subsystems (Fitzgerald & Barton, 2000). Up to the point when GST was incorporated into the field of IMH, there was a great difficulty communicating between disciplines about the explanation for the complexity in the variation between problems that were being identified within individuals and those identified within families. The GST allows for an infant to be examined within the family system but also extends our understanding of the systems concept to include the greater community contextual factors that influence the family to which the infant is growing and developing (Nichols & Schwartz, 1998).

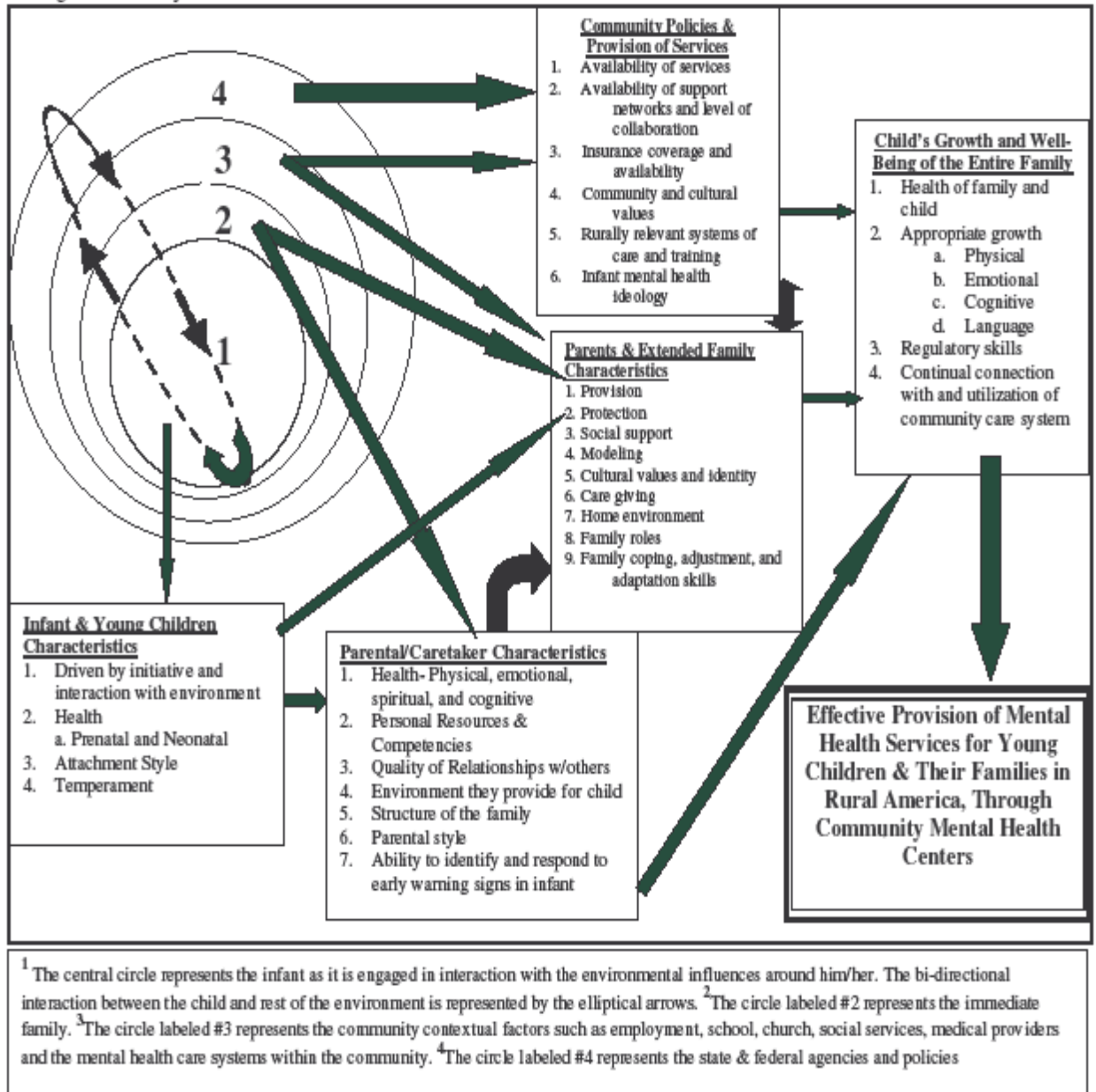
Ecological Theory

The organizational framework of the Ecological Theory (Bronfenbrenner, 1979) also contributes considerably to the Infant Mental Health field. I have chosen to place the review of this theory in the marriage and family therapy section because of its significance to the MFT field. The Ecological framework can remain in use while integrating other theoretical lenses, based on its ability to organize multiple treatment modalities and approaches for any number of different presenting issues.

This organizational framework does have an assumption about there being a larger contextual framework present for everyone and it assumes that there are pressures, expectations, and an inherent layering of concepts present. The Ecological Theory focuses on examination and explanation of phenomena. It is capable of examining the interconnectedness between the levels of analysis and then extending even further to add explanation of the impact of that connectedness. The interconnectedness is defined as the connection or relatedness between parts of a greater whole and how that greater whole relates to the smaller parts (Bronfenbrenner, 1979). This theory has the ability to bring clarity to the complexity of a phenomenon that exists at both the micro and macro levels, and then explains the entangled nature of the two levels. I have included a conceptual map, which I personally created in 2005, that details the potential assessment levels and the multiple directions of treatment that can be pursued through the lens of the Ecological Theory. The conceptual map below demonstrates how factors from each level of the theory contributes to the effective provision of mental health services to young children and their families, in rural America, through community mental health centers.

Figure 2-1 Ecological Map for Rural Mental Health for Services for Infants and Their Families

Conceptual Map for the Provision of Mental Health Services for Young Children & Their Families in Rural America, Through Community Mental Health Centers



The theory also sets out to answer a number of specific questions. For example, by which processes do families function and adapt both internally and as systems

interdependent with their environments, to assure survival, to improve the quality of life, and sustained yield of natural resources? Secondly, what adaptations need to occur to bring about human betterment? What are the roles individuals, families, and communities play in working toward desired human betterment (Doherty et al., 1993)?

Here is a brief group of definitions of a few core concepts from the Ecological framework. An ecosystem is the core of this framework and can be understood as “an arrangement of mutual dependencies in a population by which the whole operates as a unit thereby maintains a viable environmental relationship” (Hawley, 1986 p.26). The layers of this framework begin with the most fundamental level being the Microsystem. The Microsystem consists of activities and interactions in the individual’s immediate surroundings. It includes a person’s family, peers, school, church, neighborhood, etc. The Microsystem is where individuals interact with each other and their environment and is where the most primary developmental tasks take place (Bronfenbrenner, 1979).

The next layer is the Mesosystem. The Mesosystem is the relationships and/or connections among Microsystems. Examples include family’s experiences with the school, the school’s relationship with the neighborhood, etc (Bronfenbrenner, 1979). Next, the Exosystem is the experiences in social settings that affect the individual but in which he or she is not directly involved. Examples of the Exosystem would be things like a person’s neighborhood, and the network of community services available, and churches to name a few. The Macrosystem is the cultural context in which the individual lives. This addresses the widely held attitudes, beliefs, behaviors, laws, and resources of the broader society in which the individual exists. This is the cultural blue print (Bubolz & Sontag, 1993). The final layer is called the Chronosystem. It is in this level where the

historical context of the individual's development is examined to determine how the life transitions across the life span have impacted the individual (Bubolz & Sontag, 1993).

The very nature of this theory lends itself to a multilayered and multidisciplinary approach. There is so much to understand about the complexities of people and the environments where they live and the entangled nature of the relationship of the two, that, apart from the combined efforts of professionals from different fields of study, we would limit the potential outcomes from the gained understanding as the varying layers of the Ecological framework are evaluated.

The overarching Ecological framework has an inherent developmental overlay that is strengthened when used with a developmental theory such as that suggested by a family life cycle perspective (Bronfenbrenner, 1979; Carter & McGoldrick, 1990). This developmental theory illuminates the family life cycle stages and developmental shifts between developmental stages, how each member of the family transitions between stages, and how each member is impacted by the development (or developmental concerns) of the others (Olsen, 1993). This allows a sense of prediction to the development of each family member and this predictability allows for increased awareness of what is going on and allows for appropriate planning to take place (Brazelton, 1992; Olsen, 1993).

Traditional Clinical Approaches for MFTs to address presenting IMH

Concerns.

After reviewing the MFT literature, I did not find any literature that specifically discussed MFTs' clinically working with the mental health concerns of the zero to three population. Due to the apparent absence of relevant literature, I decided to further explore

the idea of MFTs' clinically intervening with families that present for mental health issues with their young children.

A qualitative research pilot study was conducted in the spring of 2005, by Corey Schliep Licensed Clinical Marriage and Family Therapist, the current author (Schliep, 2005), with three (two female and one male) licensed clinical marriage and family therapists from Eastern Kansas. All three of the therapists work or have worked within the field of Marriage and Family Therapy (MFT) and have varying levels of experience in working with young children in a clinical setting. That study focused primarily on the experiences and perceptions of MFTs, from the literature and the interviews with the three professionals, about working with young children and the resulting ideas of how they would clinically approach working with young children and their families. The questions and literature review were completed to prepare this researcher to be a well-informed evaluator of a program that specifically addressed infant mental health issues within the family context. The interview guides consisted of questions pertaining to a case scenario that I created, in order to obtain their perceptions of how they would clinically respond and treat the case. I included questions about their educational and training experiences, along with questions about their level of comfort and competence in dealing with the most commonly presenting issues within the zero to three population.

What this investigator learned was that all three participants reportedly experienced educational and training deficits, regarding clinical best practices of working with young children, as they completed their educational experiences and entered the clinical work force. Due to their reported limited, if any, training in this area, the three participants have created distinct views of their educational experiences and how those

experiences currently shape their attitudes and approaches to clinical issues, regarding young children. Each of the professionals talked freely about the manner in which they overcame or worked through the educational deficits to create their own protocol for clinically addressing the presenting issues of young children and their families. Two of the three participants reported that, early in their careers, it was difficult to find opportunities to learn about working with very young children (under three years of age). One of the participants reported that, due to their limited exposure to clinically working with the zero to three population, h/she reportedly would have chosen to only work with the parents to address the mental health issues of young children. Within their professional experiences, the youngest child who had reportedly been seen, in a clinical setting, was two and a half years old. “The play therapy techniques that I did learn, in my professional training, are not shown to be clinically reliable with anyone under the age of three,” reported interviewee number two.

Understanding that family therapy models and interventions, especially those that recognize and seek to enhance secure attachment patterns and relationships, have a natural overlap with the IMH field (Sved-Williams, 2003). Schliep (2005) reported listening for the use of language or interventions that would communicate the theoretical model being used in response to the clinical case vignette that was created specifically for these interviews. Speaking strictly from a clinical approach, there was an absence in the Schliep (2005) interviews about the use of one pure model or theory but, rather, there was the use a broad approach that focused on observation and the building of relationships with the family. Interviewee number two reported that, “I just try to understand how the dynamics of the family are contributing to the child’s symptoms. How are family

responses reinforcing behaviors? What kind of environmental stressors have been in his life related to his family.”

The most popular intervention models that were referred to, but not directly mentioned by the participants, until the interviewer asked further and more direct questions about theories and/or models, were that of the principles of the Attachment, Structural, and Narrative theories. The idea of building a strong, non-judgmental relationship with families was reported, by each interviewee and elaborated on by interviewee number two, as being critical to any effective intervention or theoretical approach. This is an indication that this therapist utilizes a Narrative approach in their clinical work. The Narrative piece would be described as their ability to be non-judgmental in their approach, providing an environment where curiosity could be facilitated, and the family would be regarded as the expert. During other interviews, the participants spoke about the importance of understanding the parent-child history and current dynamics in order to properly ascertain the attachment style of the relationship. This is clearly utilizing an Attachment lens. Schliep (2005) reported that each participant discussed how each family operated uniquely, on a day-to-day basis, and how important it is to help families understand the necessity of parental consistency and the impact that it has on providing a healthy environment for the child and the overall family system.

The interviewees discussed their identified limitations and interviewee number three further clarified that h/she felt that it would be unethical for him/her to attempt to work with the zero to three population and that it would be best to refer out to someone who has more specialized training with this population.

Based on these findings from literature and from my pilot study, there are no clinical interventions in MFT that deal directly with mental health issues regarding the zero to three population. The literature and the pilot study have identified that, theoretically, there can be successful inclusion of very young children in therapy and there is evidence that clinicians are interested in helping families with young children adjust parentally and in a familial manner. However, there is an apparent gap in the literature and practice when it comes to understanding, including, or directly dealing with the reciprocal nature of the relationships of infants. The lack of training, regarding these issues, leaves clinicians, for the most part, feeling unequipped to appropriately consider the child's influence in the relationship and to understand their individual mental health issues.

Summary of Wave Two

The historical roots in MFT are clear about the importance of gathering information about systems and subsystems in order to accurately assess and treat the system uniquely. There is also a wealth of information available, regarding the General Systems Theory's (GST) view of presenting issues, being derived through circle causality, rather than the previously accepted linear causality. GST contributed a great deal of important information to the manner in which development was perceived. Von Bertalanffy (1972) stated that relational figures mutually influence each other in a bi-directional manner. This was an important contribution because it gave power and understanding to the influence that children of all ages had on their parents and the rest of the family system, rather than merely looking at the influence the parents were having on the rest of the family.

The Ecological Theory created a framework by which to better understand and assess the mutual dependence between layers of systems and subsystems. There is a developmental overlay to this theory that adds to the understanding of how each individual, and the system as a whole, is impacted by the developmental lifecycle.

Although, MFT theories historically speak to the inclusion of entire family systems, there is little to no data demonstrating the successful inclusion of young children in the therapy process. There is, however, ample data available demonstrating MFT's discomfort with including young children in therapy. The data reveals that the discomfort does not come from a position of opposition but rather from a position of a lack of education and training. Therefore, if there was additional education and training provided, it is likely that MFTs would begin including more young children in therapy.

Wave Three: Community Mental Health Centers

Prior to the 1960's, large state mental health hospitals were the primary treatment option for individuals deemed to be mentally ill. There was little attention and few funds given to promotion, to prevention, or to the direct provision of mental health services, until the passage of the Community Mental Health Centers Act of 1963 (McPheeters, 1977). This act was derived from suggestions made by the Community Services Branch of the National Institute of Mental Health during President Kennedy's tenure. This act enabled the appropriate federal funds to be dispersed to the states to create community mental health centers (CMHC). The plan intended to create approximately 2,000 CMHCs nationally. The Community Mental Health Centers Act of 1963 ran the danger of losing its federal funding during the Nixon administration but, instead of abolishing CMHCs totally, the growth of new CMHCs was dramatically slowed. This goes along with the

trend that the need for mental health services has always surpassed the availability of the appropriate services and available programs (Elwell, 1970).

According to Elwell (1970), “a primary objective of any mental health program is to distribute resources equitably for the maintenance and promotion of mental health as well for the treatment and rehabilitation of the mentally ill and emotionally disabled” (p. 1014). In order to accomplish this primary objective, traditional services in community mental health centers have included such programs as: a comprehensive treatment link for inpatient services and outpatient services for individuals suffering from severe mental illness, mental retardation, and those with alcohol and drug issues (Elwell, 1970; McPheeters, 1977). The passing of the 1974 Community Mental Health Centers Amendments required additional services be provided for the “aged and for children” (McPheeters, 1977 p.169). During this same time period, there were some CMHCs that were advocating for prevention services, such as sending out newsletters addressing different issues that are stressors for the general public, such as the “emotional management of newborn babies and infants” (McPheeters, 1977 p.167).

These services were generally under the umbrella of the CMHCs consultation and educational services. Other prevention services included promoting the need and benefit for having affordable community housing, financial security for the poor, and the need for quality day care programs. Because of the economic crunches through the years, these preventative services have remained the object of budgetary cutbacks, primarily due to the difficulties in proving that the prevention services were effective and also because these prevention services didn’t bring in any money for the centers (McPheeters, 1977). Prior to the community mental health movement, the more traditional psychiatric

approach was said to limit the mental health service delivery to the privileged. The community mental health movement set out to achieve new mental health goals nationally.

One goal of the community mental health movement was the redress of the gross imbalance in the mental health delivery system that had made adequate care the province of the white affluent. This “bold new approach” was to be accomplished through the establishment of a national network of community mental health centers (CMHCs) to meet the mental health needs of *all* persons within the community...a lowering of the incidence of mental disorder through an alteration of social-structural conditions regarded as inimical to mental health: e.g., poverty, racism, and other social inequities (Robin & Wagenfeld, 1977 p.17).

Historically, there have been concerns regarding the clinical treatment services offered in CMHCs for children. According to McPheeters (1977), “children are often diagnosed, but seldom treated in community mental health centers” (p.165). There has been reported success in the community mental health centers movement’s attempt to provide equitable services to all people, regardless of economic status. However, the community health movement seems to be more focused on providing mental health services to all ages and in all geographic areas (McPheeters, 1977).

Rural Community Mental Health Centers

The community mental health center (CMHC), that I am going to be evaluating, is located within a rural area. Therefore, I am going to narrow my view of CMHCs down to that which directly applies to rural CMHCs.

The general concept of quality health care, including mental health care, does not change from urban to rural settings. The focus remains on providing the right service, at the right time and in the right way, to achieve the optimal outcome for the individuals and families and the communities in which they dwell. With the identified high stakes of early development and the mental health of our current and future population at risk, we must look at more appropriate and effective ways of observing and serving young children and their families within the rural context, as well as intervening more frequently in rurally relevant ways, or the long term cost of providing and obtaining mental health care will far out-weigh our ability to pay for the appropriate services (Kirshenbaum, 1983; Tableman & Hess, 1985; Watson et al., 2000).

To address any facet of rural mental health, first there needs be an operational definition of rurality and a clear picture of the complexities and core concepts that make up the cultural context in rural America. Secondly, utilizing the contextual understanding, we need to begin equipping potential providers, within their trainings at the universities, with the unique skill set that is required to successfully assimilate into and work effectively within the rural environment. There are multiple variations of the definition of rural and the perceptions of how those definitions uniquely impact mental health providers and other service providers and the level of system collaboration that can be afforded, to each rural community to address the mental health needs of infants and their families living within a rural context.

The 2000 United States Census Bureau defines rural as consisting of all territory, population, and housing units outside of an urbanized area, (with urban being defined as 1,000 people per square mile), and having less than 2,500 residents (*Census 2000 Urban*

and Rural Classification). That definition focuses on the population density and its proximity to urban areas. The Office of Management and Budget (OMB) uses the terms metropolitan and non-metropolitan, instead of rural and urban, in their definition. Non-metropolitan is defined by the OMB as an area outside of a metropolitan area and has no cities with populations exceeding 50,000 people (Stamm et al., 2003). This definition looks at the population and the community's integration with larger cities. The variety of rural definitions has prompted the United States Office of Rural Health Policy (ORHP) to devote an entire publication solely to the definition of rural (Stamm et al., 2003).

The term non-metropolitan would require an urbanized slant to be adopted into our language and into our understanding of the provision of services, thus limiting the capacity to understand and address the unique needs of the population within the rural context. Therefore, in creating an effective theoretical framework, that meets the unique contextual needs, a geographical value balance has to be maintained linguistically and ideologically. In describing rural areas as being 'non-metropolitan', a geographical bias is created and it also lends itself to social stratification, defined only by where the majority populations lives and discounts the rural minority population altogether. In an attempt to maintain the balance needed for the scope of this paper, I will only be using the terms rural and urban as defined by the U.S. Census Bureau.

To appropriately describe the count of rural Americans, Stamm and his colleagues generalized across the different definitions to report that roughly 20% of the population is considered to be rural in the United States (Stamm et al., 2003). The population of the United States is approximately 296,410,404 (*Census 2000 Urban and Rural Classification*). Of that total, roughly 11,416,676 are children under 3 years of age (*Key*

facts about children birth to 3 years, their families, and the child care system that serves them, 2006). Those statistics are based on the entire population of the United States, rather than on those areas of America that meet the criteria for being defined as rural. I found no evidence declaring any difference in population ratios of infants in the rural populations versus infants in urban populations. If you use Stamm's (2003) estimate of 20% for the population that is said to be residing in rural America, then there are roughly 59 million Americans who are considered to be dwelling within the rural context inside the United States (*Census 2000 Urban and Rural Classification*). If the ratios are basically the same for urban and rural populations (roughly 3.85 % of the total population is age 3 or under), then the population of children, ages three and under in areas classified as being rural, would equal 2,271,500.

One major difference between the urban and rural environments is that 55% of U.S. counties (all meeting criteria for rural classification) are not served by a psychologist, psychiatrist, or social worker (Watson et al., 2000), and that statistic does not include those professionals specializing in the care of the young children in our country. If primary care physicians and infant toddler specialists were included in that figure, the percentage of underserved counties would be dramatically higher than the fifty five percent reported. Studies have also shown that as many as two-thirds of all rural counties are underserved by well-trained health and mental health professionals (Hovestadt, Fanell, & Canfield, 2002). That percentage is even higher in the case of infant and toddler specialists. There are reportedly 605 counties in the United States that do not have a medical health care professional available and 1600 United States counties

that do not have mental health care practitioners present and practicing (Van Hook & Ford, 1998).

The President's Commission's Task Panel on Rural Mental Health (1978) identified the environmental factors that impact the mental health status of the population within the rural context as:

Stress due to factors associated with geography such as isolation and transportation problems; as populated by a large number of undereducated, poor, and unhealthy people; as associated with a higher than average prevalence of psychiatric disorders, especially depression, and severe intergenerational conflict. ...rural values are holistic, that functioning in the community is the "social yardstick" of mental health and that distinction between physical and mental health are seen as artificial, and that helping in rural communities is very different from urban helping (D'Augelli & Vallance, 1981 p.3).

Weigel and Baker (2002) reviewed the unique practice issues in rural settings and found similar issues present. The authors described the difficulties of transitioning into rural environments, increased need for personal independence and flexibility, increased risk of personal and professional isolation, lack of supervision and consultation opportunities, paucity of referral resources, increased generalist practices rather than specialists, increased need for collaboration, and increased need to incorporate local resources and paraprofessionals in the counseling process (Weigel & Baker, 2002).

It has proven to be difficult to find an agreed upon, contextually sensitive definition for rural that proves to be effective in assisting mental health professionals, as well as medical staff, to prepare to meet the needs of individuals, couples, and families

within the desired geographical area. It is equally difficult to help prepare, equip, and recruit providers to go out into rural America and, consequently, there have been shortages of treatment providers, leaving those professionals and families, who do live within the rural environment, isolated and, many times, without the appropriate level of care to address the concerns of the community (Kelleher, Taylor, & Rickert, 1992). Populations need to be analyzed by their social customs, norms and unique influences that are present within the demographic region in which they exist (Klein & White, 1996).

There have been problems identified in rural America, whether it is the best solutions to combat the negative impacts of the farm crisis during the 1980's or attempting to address the mental health needs of infants living within rural America today. There have been attempts to decrease the problems relating to the paucity of referral sources by established connections with urban professionals for case consultations. One of the methods utilized to connect urban professionals to rural professionals is Telemedicine.

Adequate health care services are often not available in rural and remote areas, and this problem is expected to grow worse in the near future. "Telehealth" interventions represent a strategy for addressing access to care problems. Although Telehealth services do not directly address overall shortages of clinicians, they can improve access to health services in rural areas by providing a way for clinicians located in urban areas to deliver care to rural patients in relatively distant locations (Grubaugh, Cain, Elhai, Patrick, & Frueh, 2008 p.166).

There is a great risk in assuming that one type of treatment or one way of treating, that is effective in one context, will automatically be the best treatment or way of treating within another context. I have found that urban professionals have urban ways of seeing and addressing clinical issues that may not be effective or welcomed within the rural context (Dixon & Welch, 2000; Dottl & Greenley, 1997; Huffman & Wasem, 1991). This produces another layer of critical issues in creating effective treatment approaches for young children in rural America that is rurally relevant. “Children must be seen in the context of their social environments—families and peer group, as well as that of their larger physical and cultural environments” (Fonagy, 2002 p.xxiii).

Summary of Wave Three

Since the Community Mental Health Centers Act of 1963, the mental health care needs of America’s rural population have been receiving increasing levels of attention and funding. While attending to the needs of rural America, policy makers have grappled to provide policies that met the needs of the people, while also finding the means to fund the created policies. Much of that struggle has led to policies that strive for mental health parity for reimbursement issues for rural environments and also giving more control of policy making to those at the local level rather than those at the national level. The move away from federal control has enabled localized planning but, without the appropriate federal funds, there is a growing gap in the quality of care and the quantity of care available (*Changes in Rural Communities in the Past Twenty-five Years: Policy Implications for Rural Mental Health*, 1998). There has not been a complete abandonment of rural mental health providers by the federal government.

The National Health Service Corps has been of great help to rural areas. These areas have benefited by the decision to broaden its assistance to include psychologists, nurse practitioners, and physician's assistants as eligible for benefits as well as physicians. The establishment of Rural Mental Health Research Institutes (currently eight) is creating an important source of knowledge on which to build practice and influence policy. They are attempting to keep track of changing behavioral health care needs (*Changes in Rural Communities in the Past Twenty-five Years: Policy Implications for Rural Mental Health*, 1998).

Wave Four: Community Mental Health Center of Crawford County (CMHCCC)

History and rationale for new IMH services

During the fall of 2003, Michael Ehling (Licensed Clinical Marriage and Family Therapist and the Director of Children's Services at the Community Mental Health Center of Crawford County) attended a Fetal Alcohol conference. Through the presentations and casual conversations with individuals from SEK-CAP, it became apparent to him that other community agencies were facing difficulties, working with families with mental health and addiction issues, who also had children under the age of three. These young children were experiencing delays and a number of difficulties, as a result of the issues that were facing their families. Mr. Ehling realized that these difficulties could be addressed if the CMHCCC acted as a vehicle for a cooperative effort between community staff and programs, but the appropriate community partnerships had not been established. The infant mental health clinical program was originally under the

direct administrative control of the CMHCCC and was called “the Discovery Infant Mental Health Program.” In 2007, through the financial constraints placed on the program, the two collaborating organizations entered into a memorandum of agreement that transferred official ownership of the infant mental health program from CMHCCC to SEK-CAP. Since SEK-CAP was now administratively in control of the program, it was renamed “Options” which stands for “Offering Parents Therapeutic Individualized Opportunities through Nurturing Services.”

This research dissertation project was designed to illuminate the process by which the present day community collaborative, systemic infant mental health program was created. Through the analysis of this project’s one on one interviews and program documentation, the program’s history through its current operation will be described in chapter four.

Summary of Wave Four

From the fall of 2003, Michael Ehling (Licensed Clinical Marriage and Family Therapist and the Director of Children’s Services at the Community Mental Health Center of Crawford County) began a journey to create a systemic treatment approach that could be delivered through a rural community mental health center, by collaborating with other community organization. He was able to facilitate the development of a facility to hold the 0-3 treatment center. The Discovery Infant Mental Health program went through an ownership transition from CMHCCC to SEK-CAP beginning in 2007, and the program was renamed “Options.”

CHAPTER 3 - Methodology

This research project utilized qualitative evaluation methods, in the form of a formative evaluation, to investigate the infant mental health services within the catchment area of the Community Mental Health Center of Crawford County (CMHCC). This paper explored the process by which the CMHCCC and its community collaborators designed their zero to three clinical program and how that new program is being implemented within the catchment area of the CMHCC. Qualitative methods are often used, as a part of an evaluator process, in order to get at the heart of the history of the program being evaluated, through the lens of the participants' stories (Patton, 2002). In the case of this evaluation, the participants are those individuals who took part in the creation of the program and those who are involved in the implementation of the program. My research questions focused on gaining a better understanding of the complexities of creating and delivering mental health services to individuals within the zero to three population and their families, through a collaborative community mental health approach.

This study's questions were based on the following chronological steps: an extensive literature review of the historical approaches to working clinically with the zero to three population, from the fields of Infant Mental Health and Marriage and Family Therapy, along with a review of the programs offered historically through community mental health centers for this study's targeted population previously mentioned above; a personal conversation with both program directors was completed during the research design meeting on March 19th, 2007; and after the research agreement was signed, then

the programs provided me a copy of the official program documentation and a review was completed.

Research Design

This study's design fits within Rossi, Lipsey, & Freeman's (2004) description of a qualitative approach to program evaluation and also to being classified as an outside evaluation. This classification is further reinforced by the agreement between the evaluator and the stakeholders and the fact that I am not employed by or financially connected, in any way, to the program being evaluated. A formative evaluation is a series of evaluation activities undertaken to furnish information that will guide program development and improvement (Rossi et al., 2004). Rossi et al. (2004) defined the qualitative approach to evaluation as those that:

Stress the need for intimate knowledge and acquaintance with a program's concrete manifestations in attaining valid knowledge about program's effects. Qualitative evaluators tend to be oriented toward formative evaluation that is, making a program work better by feeding information on the program to its managers (p. 400).

This definition is contrasted with the quantitative approach to evaluation which is concerned with the more outcome focused evaluations such as impact assessments and summative evaluation (Rossi et al., 2004).

It is important to not simply understand the qualitative approach to program evaluation but to also understand the more general use of the qualitative approach to research. Creswell (2003) defined the qualitative approach to research as being:

One in which the inquirer often makes knowledge claims based primarily on constructivist perspectives...or advocacy/participatory perspectives...or both. It also uses strategies of inquiry such as narratives, phenomenologies, ethnographies, grounded theory studies, or case studies. The researcher collects open-ended, emerging data with the primary intent of developing themes from the data (p. 18).

In contrast, Creswell (2003) has defined the quantitative approach to research as being, “one in which the investigator primarily uses postpositivist claims for developing knowledge..., employs strategies of inquiry such as experiments and surveys, and collects data on predetermined instruments that yield statistical data” (p. 18).

Over the years, evaluators have been challenged to obtain quality standards for the field in order to be taken more seriously. These standards have undergone some changes over time but what has remained unchanged is the four principles of the evaluation having, “utility, feasibility, propriety, and accuracy” (Patton, 2002 p. 550). The utility of this particular program evaluation is that it seeks to address the barriers that were being experienced by the program implementers and the identified barriers that were reported to the program designers so that the issues could be appropriately addressed. This study meets Patton’s reporting of evaluation feasibility standards by having a research plan that was well thought through and the appropriate steps had been taken to ensure that each step could be completed successfully, within the time frame and budget of the dissertation process, and it is within the reasonable expertise of the evaluator to complete the evaluation. The propriety standard has been appropriately addressed by the level of professionalism at which the project was approached and

carried out under the direction of my dissertation committee and the Internal Review Board of Kansas State University. The accuracy of this evaluation was upheld through digitally recording each in-depth interviews and each interview was carefully transcribed and then reviewed multiple times before any of the data was reported in this study.

Program evaluations have been utilized in a number of different fields through the years but mostly for the purposes of assessing outcomes through quantitative methods. Because of budgetary restrictions, program evaluations are becoming far more important to ensure a program's success (Cato, Chen, & Corbett-Perez, 1998). Cato et al. (1998) suggested that there are four main reasons why program evaluation is important, "1) to prevent program failure; 2) to enhance decision-making for resource allocation; 3) to assist in [program] building theory; and 4) to convey the critical importance of service providers in the success of national, local and social agendas" (p.8). Program evaluation also provides valuable insights to the staff themselves, as well as to program administrators. When an evaluation is taking place, questions are being asked that require the interviewee to think about the program's design, their role in the program, and how it is being implemented. By merely thinking about the program's design and implementation, it creates an opportunity for each individual interviewee to think, in a more focused manner, about what they do on a daily basis and why they do what they do.

When this evaluation is complete, a summary of the findings from the interviews will allow program administrators to determine if everyone is on the same page and provide them with valuable insights as to how to take their next step administratively. The responses were summarized by group and individualized responses will not be reported in any order, to help participants feel more comfortable to freely share their

responses. The next administrative steps will be vitally important to either keep everyone going in the same direction by addressing identified barriers or to get everyone on the same page and working in the same direction. The process by which I took to analyze the data will be described in detail later in this section.

Evaluation Design Considerations

This evaluator considered a number of different designs for this dissertation study. One of the first considerations was the question of where the program was in the time line of their existence. This program was in its second year of operation and this evaluator could have done a preliminary outcome evaluation with the limited number of participants that have utilized the services thus far. The limited number of participants hindered what I deemed to be a thorough outcome-based evaluation. The next consideration was that of where the fields of IMH and MFT were, regarding research on programs such as this one. Since there was a paucity of research about programs, such as the one at the CMHCCC, it was a conscious decision to determine what type of evaluation study would provide the next brick in the wall for each field. Through discussions with my major professor at the time, Dr. Mark White, it was decided that a formative evaluation would be the most appropriate evaluation approach.

I had immersed myself in the literature and did not find a formative evaluation, of this nature, in either the fields of IMH or MFT. I then determined that there was a need for further understanding about how a program, such as this one, was created and how they were progressing in their efforts to uniquely address IMH concerns, while also addressing larger family system issues, and doing all of this within the community context. This evaluator went beyond the literature to see where the field of Marriage and

Family Therapy was regarding the treatment of children under the age of three. Dr. Mark White encouraged me to contact the director of the Journal of Marriage Family Therapy, who at the time was Mike Bauwers and he stated that he had not heard of any literature dealing with MFT's working directly with children under the age of three. He stated that he would be interested in hearing more about this type of program and that it might be a valuable publication for the field.

Population and Sample

This formative program evaluation was completed at the Community Mental Health Center of Crawford County (CMHCCC), which is located in rural Southeast Kansas. It was essential for me to go into such great detail about the rural context of the CMHCCC in order to more holistically understand the target population, as well as to more fully understand the program as a whole (Patton, 2002).

The sample was obtained as a result of the organizational meeting that was held at the main offices of SEK-CAP, between the two collaborating program directors Linda Broyles and Michael Ehling, and this evaluator on March 19th, 2007. This meeting was approximately two hours in length, in which time the research prospectus was discussed and terms of the evaluation were agreed upon. Each director discussed the staff members from their respective programs, who were directly involved with program planning or implementation, in order for us to get an idea of how many interviews were going to take place. There were four total participants identified from both programs, three staff members and the program administrator. Once the targeted staff members were identified and agreed upon, we agreed to hold the interviews during a two-day period that was to be back to back days. This was done to limit the amount of time each interviewee would

have to discuss their interview process with other targeted staff members. We agreed that it was important to allow everyone to answer questions with the least amount of bias from other interviewees. We also agreed to inform each interviewee to not discuss the interview process until after the two-day interview period is concluded. Each interviewee will be assured that their responses will not be used against them in any way and that there would be measures taken to ensure their confidentiality. To do this, each participant's responses was assigned a number that was only be known by this investigator. The findings were combined and summarized to reduce the likelihood that any particular answer given could be identified as coming from a particular staff member. Further understanding of the approach taken to protect participants will be discussed in the protection of human subjects section.

The two directors spent time, during team meetings and personal interactions with the designated staff members, from the time of our meeting in March to the time of the interviews, discussing the benefits of participating with the evaluation process. It was made clear that the staff members were not being evaluated but the program design and implementation was being further explored.

I had considered expanding the sample to include interviews with client families that have received services from this program during its first two years of operation. I decided not to include client interviews, based on the limited number of participants utilizing the program's services. Their contribution will be essential in future studies. Their contribution was determined to be outside the scope of this project and would have been ahead of where the gap in the research is at the time of this project. Ideas of

appropriately including client feedback will be included in my thoughts and suggestions for future research projects.

Protection of Human Subjects

Each of the interviewees agreed to participate in the evaluation process by signing a consent form to be interviewed and to have the interviews digitally recorded. Each interviewee also was informed about the purpose of the study (Appendix A) and I personally informed them that the evaluation is of the program and not of their particular work performance. Each interviewee was also given a briefing statement, prior to the actual interview taking place, which outlined the risks associated with being interviewed for this evaluation. The potential risks were seen as including increased distress, due to answering questions and thinking about difficult planning and treatment decisions, which have been made by the interview participant. Additional risks include potentially losing anonymity and the potential fallout that could occur with peers and with the administration personnel, such as being ostracized either professionally or personally because of their sharing their views (Patton, 2002). Even though their views were kept as confidential as possible, there was a risk of exposure to their identity due to the small sample size. Confidentiality was vitally important to me and I worked to maintain their identities by protecting each participants' contact information. No names were linked to the data and all participants were assigned a participant number for tracking purposes. All records were kept in a locked cabinet, with access only by this researcher. Since this is a program evaluation, and there is an ongoing partnership with the multiple stakeholders, each program director was given only the required interview findings and not the detailed raw data that could link the interview data with the specific participant. I

will appropriately destroy all recordings within one year of the completion of the evaluation project.

I acknowledge the potential of the program directors, and other staff participants, being able to link particular interview statements with specific employed personnel. The potential of the directors and/or staff members identifying the individuals responsible for any particular comment presents a unique tension between using too much direct information from interviews and summarizing the findings too much. I wanted to get as close to their actual words as possible without jeopardizing their anonymity, but not summarize the findings so much that my own personal biases taints the findings.

To minimize the potential harm that could come from the identified risks, each interview participant signed off on the consent form to acknowledge their understanding of the potential risks and the harm that could result if the risks become actualized. Each interview participant also signed off on the information from their interview that I utilized for the final writeup; this included any direct quotes or summaries of their information. They did this through phone conversation or email. Due to the identified risks, each participant was given referral information, as a part of the debriefing statement, to the appropriate community resource to minimize the impact of the potential risks associated with this project. It was my belief, that by providing the referral list to them, at the time of the interview, they would be more likely to utilize the community resource if symptoms of distress should arise. A copy of this debriefing statement can be found in Appendix D.

Means of Data Collection

I completed eight in-depth, semi-structured, interview guide type interviews with the following designated staff from CMHCCC: two community health staff nurses, one clinical marriage and family therapist, and the clinical director/program creator. I also completed four in-depth, semi-structured, interview guide type interviews with the following designated staff members from SEK-CAP: the program coordinator for Early Head Start (ages zero to four), the Program Manager for ages zero to four, the Assistant Director for Early Childhood Services for SEK-CAP, and the program administrator who has two distinct titles: Director of Early Childhood Programs and Deputy Director of SEK-CAP. Each of the semi-structured interviews were based on questions derived from a literature review of the field of MFT, specifically in the area of MFT's experience of working with young children, and the field of Infant Mental Health in the areas of theory and best practices. This evaluator completed each interview and I expected the interviews to be between 40 minutes to one hour in length. The interviews ended up being a minimum of 49 minutes long and a maximum of 120 minutes. A copy of the interview protocol may be found in Appendix B for the administrators and Appendix C for the Clinical Staff.

I could have had the participants complete a survey to gather the pertinent information regarding their experiences but the survey method limits my contact with the participants, and requires more known variables to study that I did fully have prior to the interviews and I was interested in obtaining the information from the participants during the face-to-face interviews. The other option would have been for me to coordinate a focus group session for each organization participating in the evaluation but a focus

group format depersonalizes the individual experiences of each participant and allows for too much 'group think' to take place. The individual in-depth, semi-structured interview approach allowed me to interact with each participant and diminished the possibility of restricting the participant's experiences of the complex process of creating and operationalizing this program.

Means of Data Analysis

One of the main challenges of all qualitative studies, including this formative program evaluation, is determining how to take the volume of information discovered through the one on one in-depth interviews and then produce findings from that data (Patton, 2002). As I have already described the process of collecting the data, I will now discuss how this evaluator transformed the data into findings. The process of qualitative analysis began with the completion of the interviews themselves. Patton (2002) believed that "findings emerged out of the data through the analyst's interaction with the data" (p. 453) and I began interacting with the data as each interview was taking place. Once the interviews were completed, the digital recording of each interview was saved onto my hard drive for safekeeping, which is controlled through a password that is known only to the researcher. In that manner, I had easy access to the data for reviewing each interview. The same paid professional transcribed each interview. The transcriptions were all then reviewed by myself and compared to the digital recordings of the actual interviews to ensure the accuracy of the transcriptions and to further immerse myself in the data. One year from the date this study's completion, the raw data will be properly discarded by the researcher.

Each interview utilized the same semi-structured open-ended questions, which allowed me to compare and contrast the different interviews against each other and then compare them also to program's organizational documents (Patton, 2002). The process by which the data from one interview is cross-checked against the data from other interviews is called *triangulating* the data (Creswell, 2003; Patton, 2002).

Upon the successful completion of all of the interviews, I then determined what information was going to be utilized in the final write-up. I determined what information to use in the final write up by reading and rereading each individual interview to flesh out the overarching themes.

The original intent was for each interview participant to be sent an official report that included the portion of the write up that was taken from their interview, to ensure that each piece of data properly represents what they had intended to describe to me. The original design would have included a written report with five faces that were posted after each particular finding of their interview being utilized to determine how much they feel my interpretation matched with what they intended in their answers. The faces were to be arranged from a look of disgust to excitement (a copy of an example of the faces continuum is located in Appendix E). This approach had to be altered due to time constraints for this investigator. This investigator had to be scheduled for imminent surgery and therefore instead of sending the information to each respondent through the mail, the data was reviewed over the phone or through email with each participant. This allowed the participant to fact check the initial answers that they gave me during the interview, and I allowed each participant the opportunity to ask any questions they had of me during the phone follow-up. I did follow up also with both directors to further clarify

the program documentation. This process of allowing members to review their answers and my findings is what Creswell (2003) calls *member-checking* (p.196).

Reliability and Validity

Unlike the quantitative approach to research, where there are formulas and direct statistical measures to determine the significance, validity and reliability of a study's findings, qualitative research relies solely on the "analytic thought processes" of the researcher (Patton, 2002). Patton (2002) continued by stating that he believed "in short, no absolute rules exist except perhaps this: Do your very best with your full intellect to fairly represent the data and communicate what the data reveal given the purpose of the study" (p. 433).

I worked to maintain a high level of internal validity by utilizing multiple data sources (organizational documents, responses from individual interviews, and a broad literature review) to use the process of triangulation to best understand the themes that developed. By using individual, face-to-face interviews, I was also able to better control the external influences on the individual's unique experience of the program's creation and operationalization. Each interview utilized the same semi-structured open-ended questions, which allowed me to compare and contrast the different interviews against each other and then compare them also to the program's organizational documents (Patton, 2002).

If I had decided to utilize a survey method, I would not have had the certainty of knowing who filled out the survey, what conditions (environment, context, and mood) were present when the survey was being filled out. I acknowledge that I cannot completely control the conditions, especially the mood in which the participant is

answering questions, but I can take steps to ensure the highest degree of consistency in the conditions in which the interview process takes place. As a part of ensuring the highest degree of consistency, I added to the external controls by holding the interviews during a scheduled two-day period and all of the interviews will be held at the same location. This will limit, but will not completely eliminate, the amount of discussion between participants about the study. I asked each participant to not discuss the interview with any of their co-workers until after the two-day interview period was over.

I did as Patton (2002) suggests by utilizing my full intellect to fairly represent the data. As the researcher, completing a qualitative study, I have to be aware of what I bring to the study. I am a Licensed Clinical Marriage and Family Therapist, who has completed over 500 hours of direct services with infants and their families, along with trainings and continuing education courses dealing with infant mental health issues. I have been in MFT practice for approximately eight years and have worked clinically with infants and their families throughout that time period. The experience that I bring to the study helped me to ask informed follow-up questions and aided me in the understanding of what the participants were discussing with me. I worked to not assume that I already understood the participant's clinical experiences, for I know that each clinical situation is a unique experience and I wanted to remain interested in better understanding each of their individual experiences. I also recognized that I had never worked in an agency setting that had a program that clinically addressed infant mental health issues. I also had never created a collaborative community approach to addressing infant mental health issues. Understanding this up front allowed me to remain a curious interviewer.

I became interested in infant mental health during my clinical internship, which was working clinically with women who were either pregnant or who already had a child under the age of three. I co-facilitated a group in Topeka, KS called “*Baby Talk*” with a world-renowned child psychiatrist named Dr. Martin Maldonado. This is a man who took me under his wing, during my internship, and I am forever grateful for his tutelage. He invited me to participate in the multi-disciplinary team’s weekly sessions at the Menninger Clinic. This group was comprised of professionals who were all passionate about infant mental health. This multi-disciplinary group would meet weekly for two hours, during which a few alternating clinicians would directly provide services to a client system including infants and their families, while the rest of the treatment team would monitor the session through a live video feed in another room. After each session, the group of professionals would debrief together and share treatment thoughts and ideas to best meet the needs of the entire client system. During a few of these sessions, I was asked to present cases and participate in the treatment room. The more that I attended these treatment sessions, the more passionate I became about this specialty area. To this day, I have loved dovetailing my training opportunities and focused readings with my coursework in my masters in MFT and my doctorate program in MFT.

Limitations

I understand that every study has limitations and I will now identify the limitations that do exist within this particular study. The first limitation is the retrospective nature of the interviews. By asking individuals to recall events and experiences from the past lends itself to the possibility of the participants’ not accurately recalling the information. I recognized this as a limitation but, through the process of

triangulating the data from multiple sources, I believe that I have compiled an account of the steps taken to create the program and have accurately portrayed the experiences of the participants. As far as the individuals' remembering their experiences, I acknowledge the fact that they might not have remembered everything about their unique experience, but I chosen to value the remembered experiences and views from each individual interviewee, regardless of the quantity of data that they recalled. The amount of time between the experiences and the interview might actually allow participants to evaluate their own experiences, through an aged lens that allows them to understand their experiences in a more holistic manner. This might not be true of each individual interviewed. Some may have had a tendency to generalize their remembrances of their experiences, rather than more clearly understand individual experiences from different moments of times throughout the last few years.

CHAPTER 4 - Results

The qualitative analysis of the semi-structured interviews illuminated the participants' perception and understanding of the history and developmental process of this program and the current functioning of this collaborative, systemic infant mental health program. In order to address the stated research question, I followed the "story telling approach", which is the overarching categorization of "Options for organizing and reporting qualitative data" (Patton, 2002). I utilized the "flashback approach" (Patton, 2002) to tell the story of this collaborative, systemic infant mental health program in South East Kansas, based in the catchment area of the Community Mental Health Center of Crawford County (CHMCCC). The "flashback approach," as defined by Patton (2002), is when the evaluator "starts at the end, works backward to describe how the ending emerged," (p.439). The rationale for this approach was this: I wanted to tell the story of what this program is currently doing and how it was being done. By interviewing the staff and administrators, it allowed this project's findings to better illuminate both the developmental process and any process or procedural obstacles to maintaining and improving the quality of the program. The Community Mental Health Center of Crawford County provided the official program documentation. The data from the program documentation was utilized to create the year-by-year review of the program.

The interviews were all digitally recorded from the beginning to the end of the interaction. I began each interview with a brief overview explanation of this research project and then described to them the consent form. The participation in this project was voluntary and participants were not coerced in any manner. Each participant signed the consent form willingly. At the end of each interview schedule, I asked the participant to

review for me their response to the type of questions asked, their experience of the interview, and then I inquired as to their feelings of being open to an outsider versus an insider. After this segment of questions, I then provided each participant with a debriefing statement that thanked them for their willingness to talk with me and to be interviewed for this project. I also included referral information in the debriefing statement for the remote possibility that they could experience any trauma or disturbance from being interviewed. The probability of trauma occurring from participating in this project was seen as being minimal but the referral information was provided at the time of the interview to optimize the referral process. This way, all participants would have the referral information up front and would not have to seek out the information at a later time and, in my view, would minimize any obstacles for the participants to utilize the referrals.

I broke this chapter into four subsections. The first subsection is that of the current status of the program, utilizing the official program documentation of its history. The second subsection is program documents report of the developmental process from 2003 through 2007. The third subsection is the findings for the perceptions and experiences of participants of the program's development and operation. The fourth section contains a summary of my experience with the two data sets throughout this evaluatory project.

Participants

In the following paragraph, I am going to describe the interview participants. One of the two program directors is Michael Ehling, a Licensed Clinical Marriage and Family Therapist and a Clinical Psychotherapist and has held these credentials for the past

twenty-three years. The second of the two program directors is Linda Broyles, who has extensive experience in the field early childhood education and services. She has worked in the field for the past thirty years. She has worked her way up through the ranks in Early Head Start from a community volunteer to her current position as the Deputy Director of South East Kansas Community Action Program (SEK-CAP) and Director of all Early Childhood Programs. The employees of the programs were not be listed by name, in an effort to protect them from any potential persecution from peers or supervisors. Their positions were described but, when their quotes were used, they were not directly identified. This was agreed upon before the evaluation process began. I interviewed three employees from SEK-CAP and three employees from CMHCCC. The three employees from SEK-CAP were the Assistant Director of Early Childhood Services, the Program Manager for zero to four who oversees and supervises the home-based services and also the center-based program with childcare built in, and the Program Coordinator zero to four, who supervises family educators, for Early Head Start, who participate in the home-based program. The CMHCCC employees, that were interviewed, included the infant/toddler mental health specialist (who also was a Marriage and Family Therapist), the program nurse, who is a registered nurse with a masters degree in nursing and as well as a masters degree in science education with over 40 years of experience in the field, and also the public health nurse, who splits time between the Public Health Department and CMHCCC.

An Overview of the Options Program's Current Status

In September of 2008, the "Options" program (*Offering Parents Therapeutic and Individualized Opportunities through Nurturing Services*) was in its second year of

operation and it continued to operate as an ongoing collaboration between the South East Kansas Community Action Program (SEK-CAP) and the Community Mental Health Center of Crawford County (CMHCCC). The program is now operating as a fully integrated early childhood program, which is serving children ages zero to five years old. According to the interview data, integrating the programs for zero to three and three to five year olds was done to best serve the entire family effectively and in the most economical manner possible. During the interview process, it was reported, “in today’s economy, you have to trim expenses anywhere you can and maximize all budgetary monies or the program will no longer be able to exist.”

The “Options” program is a relatively expensive program to operate. “Anytime you serve infants, it is going to be expensive because it takes more staff in the classroom environment (a 1 to 4 ratio for infant to teacher). One of the program directors stated that “the program employs a comprehensive approach, including the mental, physical, and social aspects of growth and development.” This program director continued by describing the process by which they overcame this stark financial reality for their organization. They reportedly countered the high operating costs by designating 25% of their available classroom slots (4 slots) as paid community slots. The rest of the slots (12 slots) are allocated for Early Head Start and Head Start children. The Director of Early Childhood Services, through SEK-CAP, who at the time of this evaluatory process was Linda Broyles, had budgeted monies to cover consultative mental health services with CMHCCC. To further clarify the state requirements, regarding appropriate staff ratios for childcare centers, I have included a table below that was created by the Kansas Department of Health and Environment (2008).

Table 4.1 This is a reference to the required childcare staff/child ratio for the State of Kansas (*Kansas Department of Health and Environment, 2008*).

Age of Children	Minimum Staff/Child ratio	Maximum Number of children per unit
Infants (2 weeks to 12 months)	1 to 3	9
Infants to 6 years	1 to 4 (max. 2 infants)	8 (max. 4 infants)
Toddlers (12 months to 2 1/2 years, if walking alone)	1 to 5	10
2 years to 3 years	1 to 7	14
2 1/2 years to school age	1 to 10	20
3 years to school age	1 to 12	24
Kindergarten enrollees	1 to 14	28

The CMHCCC was able to provide updated statistics for 2007 for Social Rehabilitative Services (SRS), completed as a requirement for the Early Childhood Mental Health grant criteria. Below you will read the actual ‘Program Narrative Report’ that was submitted for the 2007 grant period. The questions that are required to be answered are recognized by being underlined by this investigator. The rest of the document is presented here in the same manner that it was presented to SRS (*Community Mental Health Center of Crawford County: Program Document, 2007*).

1. Program Summary

a.) Give a short description of your program. (underlining added)

- Screening & Assessment Tools utilized. *We continue to use the*

*ASQ: SE, but are in the process of exploring the use a universal SE tool (The **ABLE: Attention, Behavior, Language, and Emotions**) developed by Dr. Barbarin from the University of North Carolina. The ASQ: SE is utilized as a standard tool for all Head Start programs, at entrance and then 6 months later. The agency has purchased the ITSEA & BITSEA assessments as well as the Devereaux. Staff were trained in the use of the Devereaux, both classroom and clinical.*

- Describe activities and percentage of time providing **Individual-level activities** (screenings, assessments, planning for children with special needs, direct interventions etc.) (underlining added)
80% of allotted time was spent providing individualized consultation for specific children's needs. One specific case involved providing consultation to an individual family as well as a home childcare with a child whose mother was being deployed to Iraq. Consultant provided creative ways to maintain connections in mother's absence.
- Describe activities and percentage of time providing **Program-level activities** (providing staff training, supporting staff wellness, coaching/mentoring, working with management team, etc.) (underlining added)
20% of time was spent providing program level consultation. Specific to one program that had several children with sensory

integration issues, staff provided techniques, strategies, and activities to adapt curriculum to meet several children's needs in that particular setting. Weekly clinical meetings with the collaborative project with Early Head Start (center-based option) continue. Specific cases are discussed and strategies are developed that impact the program. Staff are supported with feedback and interventions through observation while providing the childcare. Quarterly evening informal get togethers with a meal and discussion of identifying training needs, collaborative growth, etc. occurs with OPTIONS (Early Head Start/CMHCCC project).

- b.) Describe how your program is meeting the goals/objectives in your proposal for children, families and childcare providers for children ages birth to five. (underlining added) *Training this quarter was not formal, but rather informal with specific early childhood providers. One additional provider (home childcare) was added this quarter.*
- c.) Please describe any activities or barriers to service provision and what has been attempted in order to overcome these barriers. (underlining added) *One of the barriers has been accessing home providers. As a group, they tend to be more isolated and hesitant in seeking out supports. The one provider that did seek out consultation was caring for a child that had already become a client of the CMHC and the parent requested assistance to the home provider. The local Resource and Referral Infant/Toddler Specialist has made a referral for*

consultation, but the home provider has not been willing to seek support at this time. Early Head Start has also made a referral through one of their contracting childcare homes, but they as well have not sought out the support at the request of EHS. It appears to be some stigma, even with MH consultation. We continue to educate about the service and normalize providers' fears.

d.) Please describe how you work collaboratively with other organizations and identify these partners? (underlining added) We developed a memorandum of agreement for the Discovery OPTIONS project with Early Head Start. Mental provides consultation as well as clinical mental health services to the high-risk population that is mutually served by both agencies in the center based EHS childcare. We also have an agreement with the local hospital, Mt. Carmel Regional Medical Center, to provide voluntary screenings for all parents delivering infants at birth. The KEMPE screening tool (this is a measure of parental risks for child maltreatment and/or caregiving difficulties for children of all ages. This measure is completed through direct parent assessment, and it requires specialized training to administer, score, and interpret) (The KEMPE Center For The Prevention and Treatment of Child Abuse and Neglect, 2008) is used to make referrals by OB nurses and offer supports and services from CMHCCC if the score is in high risk range and if the families desire services. Contacts with childcare and home preschools are also made through Smart Start mini-grants that require a face-to-face contact in order to receive the grant money for supplies. Mental health consultation

is offered at that time to the service provider. Smart Start also provides Early Childhood MH consultation through a co-employed arrangement through the Family Resource Center. Since the ECMH consultants are both employed by CMHCCC, referrals are mutually shared when needed to respond to a request for consultation in a timely manner.

2. Unduplicated number clients served (assessments, observations, consultations)

Number of: children screened 37

Consultations with children 27

Children referred to further services 12

How many individual families have you consulted? 0

How many childhood providers/programs have you consulted? 9

How many children (unduplicated # of total children attending each program) were affected by consultation through collateral contacts? 166

How many children were diverted from expulsion? 14

(Community Mental Health Center of Crawford County: Program Document, 2007).

Upon reviewing these reported numbers, I emailed Mr. Ehling to further clarify what the numbers meant. One of my questions was “Why is there a report of zero family consultations?” He responded by saying that he believed that it was difficult to say for sure, but he felt that families may just not have wanted the services (Michael Ehling, Personal Communication, September 29th, 2008). The second question, that I asked him

was, “What is a collateral contact considered?” He stated that a collateral contact was when, “a child that was being served in a program with which we provided consultation. Considered collateral if the program received the consultation or if the child indirectly or even directly received benefit because we acted in a consultation role,” (Michael Ehling, Personal Communication, September 29th, 2008).

The current program utilizes a number of different instruments with the families in the program. Linda Broyles (2008) stated that,

“Information from NCAST is being used as we work with families to develop bonds with their children. It is all about relationships: relationships, which includes those between parent & child, caregiver & parents, caregiver & child.

We work very hard on the bottom level of the Teaching Pyramid. We use ASQ: SE to determine social emotional development, the Denver II for a developmental screen, Early Communication Indicator (ECI) to assess language development and a variety of other tools” (Broyles, 2008).

The numbers of children served has increased from eight children, while the program was under the direction of CMHCCC, to 16 children under the direction of SEK-CAP (Broyles, 2008). Although there were some changes in treatment approaches from CMHCCC control to SEK-CAP control, which will be further described later in program’s developmental overview and again in chapter five, the overall capacity to reach families in need has increased. According to Broyles (2008), the program’s 16 available slots are typically full, with a wait list for the Early Head Start slots and occasionally the program has not filled the 25% of slots reserved for community members. There is no requirement for the community slots to be filled, “they only have to

have the desire to have quality care for their children” (Broyles, 2008). The inability to keep the community slots filled was thought to be due to the negative stigmatism that goes with Early Head Start children. “Sometimes it is due to the fact that some folks in the community do not want their children exposed to ‘those Head Start Kids’” (Broyles, 2008).

An Overview of the Program’s Developmental Process

Research Question

Research Question: Illuminate the process by which CMHCCC created the new approach to treating Infant Mental Health concerns within the infant, their family, and the greater community context, and determine how it has been operationalized during the first two years of operation.

In order to address the research question, I utilized the official program documentation, provided by the CMHCCC, to lay out the year-by-year development of the program. The program documentation (*Community Mental Health Center of Crawford County: Program Document*, 2007) reported that Michael Ehling had a number of conversations about infant mental health needs, with the Early Head Start (EHS) and Head Start (HS) staff members and their leadership personnel in 2003. Mr. Ehling was also having conversations with the Executive Director of the CMHCCC about the need for IHM services in South East Kansas and the potential of the CMHCCC addressing those needs. The Executive Director of the CMHCCC was reportedly very receptive to the idea and encouraged Mr. Ehling to continue pursuing the program’s design, and to ascertain what assets were already available and then begin identifying any additional

needs (*Community Mental Health Center of Crawford County: Program Document, 2007*).

At that time, the Discover Center was identified as an available asset. It was utilized for therapeutic psychosocial groups for preschool and kindergarten aged children but there were still glaring needs that required additional services. Together with the Executive Director, Mr. Ehling met with the CMHCCC's Board of Directors to describe to them the process of identifying the need for additional services within their community and the catchment area. The Board of Directors agreed with the need for IMH services for prevention, early identification, and treatment. They determined that the best way to proceed with the provision of services was to create additional space that could be used for a therapeutic daycare and for the provision of IMH services. At that time, there was a large 8,000 square foot parking garage, next to the CMHCCC's Discovery Center building, that was going up for sale. The board determined that purchasing the parking garage next to the Discovery Center would be ideal to meet their needs and they were successful in their pursuit of the building. They voted to remodel the garage in order to house the therapeutic day care and for the provision of IMH services (*Community Mental Health Center of Crawford County: Program Document, 2007*).

As the remodeling process was underway, Mr. Ehling began enhancing community contacts and those community contacts (Early Head Start, Parents as Teachers, Birth-to-3, and the Unified School District 637) began meeting to develop an understanding of the common goals shared by all of agencies, which were beginning to identify themselves as stronger community partners. According to the official program

documentation (*Community Mental Health Center of Crawford County: Program Document*, 2007), the agreed-upon goals and objectives were as follows:

Goal #1—Increase rate of early identification efforts and utilize referral sources;

Goal #2—Increase rate of home placement;

Goal #3—Increase rate of Staff and Parents working in partnership;

Goal #4—Increased Parent Satisfaction Rate;

Goal #5—Increased number of Children entering Kindergarten ready to learn.

It should be noted that, even though none of these goals and objectives specifically mentions the zero to three population, these goals and objectives were identified by a group of collaborators who, together, agreed upon the importance of the zero to three time period.

All of those goals were identified during the creation process in 2003. Also during 2003, the group of community collaborators identified some initial service barriers. These barriers included: transportation problems, training issues, paucity of prevention funds, Medicaid funding issues, and the lack of an agreed-upon definition for Serious Emotional Disturbance (SED) (*Community Mental Health Center of Crawford County: Program Document*, 2007). These service barriers were consistent with those described by Weigel & Baker (2002) for providing services in rural America, which also included an increased risk of personal and professional isolation, lack of supervision and consultation opportunities for professionals providing direct services, and a paucity of referral resources (Weigel & Baker, 2002). The lack of supervision and consultation opportunities to those, who are directly related to the provision of services to the zero to

three population, creates even a more substantial barrier than those found in other medical and mental health services.

According to Telesford (1996), developing effective mental health services within communities requires community collaboration (p. 64-65). Telesford (1996) continued by stating that mental health programs must build upon those strengths already existing within the community. In order to reform a system of care for children, Telesford (1996) believes that you must begin by developing strong relationships and partnerships with community-based organizations that are already delivering services to the target area (Telesford, 1996 p.64-65). The CMHCCC began their new efforts by working to build collaborations within the existing mental health and social services community. They began to work collaboratively with the local Early Childhood Coalition and, together, they hosted an Early Childhood Summit that was held in October, 2004. There were approximately thirty individuals from twenty-five area agencies and three parents from Early Head Start, Women's Day Treatment, and Mental Health (*Community Mental Health Center of Crawford County: Program Document*, 2007). Out of this summit came the understanding that there was a need to have an Infant-Toddler Mental Health Specialist employed within the CMHCCC catchment area. This position was funded through a Smart Start Grant, and was officially filled in January, 2005, to accomplish the following objectives:

Early Childhood Mental Health consultation to early childhood providers, especially childcare and preschools to prevent expulsion; training for providers in the early childhood system of care on IMH concepts, interventions, support, etc.; Treatment for families 0-3; and system development, specifically around utilizing

the ASQ-SE (Ages and Stages Questionnaire-Social/Emotional) as a system's wide screening tool to identify children with social-emotional difficulties and refer them for appropriate care. This position will be co-funded with one half coming from the Smart Start grant and one half coming from CMHCCC (*Community Mental Health Center of Crawford County: Program Document, 2007*).

During this time in the program's development, a contract was signed with Early Head Start. This contract stipulated that there be center-based IMH childcare services provided through CMHCCC. Even though the admission criteria had not been officially finalized, it was understood that,

“Women with substance abuse or psychiatric disorders with infants or toddlers will be eligible for the child care. As a part of their Temporary Assistance for Needy Families (TANF) requirement, mothers will be required to participate in parent/child interaction therapies. Early Head Start will underwrite the childcare portion hopefully creating a more stable financial base. Treatment would be billed under Medicaid for family therapy” (*Community Mental Health Center of Crawford County: Program Document, 2007*).

CMHCCC applied to become a Medicaid provider, which they were granted acceptance during the 2004 fiscal year.

There was original start-up monies made available from SEK-CAP, which created capacity-growing opportunities for both SEK-CAP and the CMHCCC, especially in the area of infant mental health training. During the spring of 2004, staff from the CMHCCC was beginning to be designated for IMH training. The IMH trainings included Family

Infant Relationship Support (FIRST), a National Zero to Three Conference in Sacramento, CA, and a seminar on Attachment and Working with Families in Homes were completed. Staff also attended conferences in Topeka, KS on IMH, and the perinatal conference on the 'Impact of Maternal Psychiatric Issues on Fetal Development' was attended by one staff in Topeka, KS. Another seminar, that was reportedly important for a number of staff members, was the Dr. Bruce Perry seminar in Wichita, KS (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Historical Overview of the Program

The Target Population:

The targeted populations to receive the new services through the community collaboration, under the umbrella of the Community Mental Health Center of Crawford County, were women within the CMHCCC catchment area, who were pregnant and were currently suffering from psychiatric disorders or who had been identified as having substance abuse disorders. The adult caregivers were screened using the DSM-IV. to determine the presence of any psychiatric disorder; Attachment Scales were used to clarify the adult attachment styles; and Parenting Stress scales were utilized to further identify areas in which risk factors were present, and the potential manner in which the program could help to decrease the presenting risk factors (*Community Mental Health Center of Crawford County: Program Document, 2007*). The program also targeted infants and toddlers, who had been identified to be at risk of having been prenatally or postnatally exposed to substances, violence, and/or trauma of some kind. The infants/toddlers were also screened through the use of the Denver II, ASQ-SE and the

DC-03 to determine if there was the presence of a relationship disturbance, such as problems with bonding or attaching with their primary caregiver(s) (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Treatment Philosophy

The overarching treatment philosophy was established through a foundation built upon the idea that no one was going to be rejected or ejected from the program. Upon that idea, the program strived to maintain a culturally competent, relationship-based approach to creating all treatment plans. All treatment plans were centered on the family and child and were grounded in strong developmental principles. Lastly, the program strived to provide these services in the most natural setting as clinically possible and aimed to maintain the family and child in their natural setting. The Treatment model for the program was designed around a cooperative blending of multi-disciplinary, wrap-around home-based, and center-based care service options. The home-based care utilized in-home family therapy and case management services to meet the needs of the family system. The center-based care options included such things as therapeutic child-care services, assessment services, and parent-child psychotherapy (*Community Mental Health Center of Crawford County: Program Document, 2007*).

I will now provide the reader with a program summary beginning in 2003 and then going year-by-year up through 2007.

Program Summary 2003

During 2003, Michael Ehling began attending conferences focusing on the mental health needs of the zero to three population. The activities of this year were described in

detail above. The result of the initial stages of program operation yielded some promising results toward their overarching goals (*Community Mental Health Center of Crawford County: Program Document, 2007*). The CMHCC staff members were trained in Positive Behavioral Support as a part of the cooperative agreement with Early Head Start.

Progress towards goal:

Goal #1—Increase rate of early identification efforts and utilize referral sources;

The Discovery Infant Mental Health Program was able to provide social skills groups in the community with SEK-CAP Head Start and USD 637 Interlocal. This integrated model included three early childhood special education classrooms in two elementary schools and one family resource center (*Community Mental Health Center of Crawford County: Program Document, 2007*). Social skills groups are seen as teaching specific social skills through direct instruction, modeling, and a wide variety of hands on activities. Each individual typically joins a small group according to language abilities, social functioning, and temperament.

Goal #2—Increase rate of home placement;

They reported having fewer than 15% of children in their ‘Discovery Infant Mental Health Program’ removed from their homes. They were successfully linking more families with the program and the homes of the families through the increased usage of case management services (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #3—Increase rate of Staff and Parents, working in partnership;

The program reported greater cooperative efforts in partnering together between the program and the parents. The program’s team also got together, as a staff, and

developed goals to improve outreach to parents. These outreach goals were not enumerated within the program's official documents (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #4—Increased Parent Satisfaction Rate;

The program handed out forms to test satisfaction to all parents and encouraged parents to give the program feedback. The program's documentation reported that parents rated the program's services as 'very good' (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #5—Increased number of Children entering Kindergarten ready to learn.

Even though this goal was for kindergarten-aged children, it was a reflection of the presence of zero to three programming. Children that had ongoing and yet undetected mental health issues were more likely to enter school, requiring additional educational and/or behavioral supports. The program reported having only one out of ten children requiring an Individual Education Program (IEP), which was for speech therapy. "There were no referrals made to Cherokee Village, an alternative behavior disordered school" (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Identified Barriers

CMHCCC staff and administrators identified service barriers. They identified a pattern of increasing referrals for young children who had co-occurring disorders, mainly presenting with Pervasive Developmental Disorders, behavioral problems, and mental retardation (MR). CMHCCC worked together with MR providers to sort out roles and responsibilities, in order to properly address all presenting issues in the most effective manner possible. It was reportedly difficult to administratively coordinate this

cooperative effort. Transportation for families and providers was also identified barriers. A large contributing factor to this issue was the high rates of poverty in catchment area where the CMHCCC provided services. The cost of travel was a barrier for providers and participating families. They worked together with schools that were located in the outermost areas of the catchment area in order to make the services more accessible to everyone (*Community Mental Health Center of Crawford County: Program Document, 2007*).

The paucity of prevention funding was also a barrier to providing infant mental health services. The mental health services that were billable were billed through Medicaid as family therapy. This unfortunately could only occur once a problem or concern had been identified and it was an option that would not assist in funding early detection or prevention efforts (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Another barrier was the policy related difficulties being experienced between CMHCCC and Head Start. The points of concern were related to program mandates and how the two programs could properly observe the mandating guidelines for the Head Start program and best serve the targeted population. The two agencies worked together and renegotiated their contract to best serve both agencies and participants. This required CMHCCC to complete training in Positive Behavioral Support. There were also some concerns raised over the definition of terms, mainly regarding how Serious Emotional Disturbance (SED) was going to be defined. The two organizations were unable to completely resolve this issue during the 2003 program year but were able to maintain

their service contract and remain engaged in dialogue around their concerns (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Program Summary 2004

The CMHCCC continued to experience difficult growing pains internally relating to the remodeling/transformational process of the parking garage into a space for therapeutic childcare center, which began in January 2004 and was completed in September 2004. There also were growing pains between collaborating agencies, mainly with Head Start. The two organizations reworked the contract but this was a time-consuming endeavor and the families in the program were unable to obtain mental health services during this lengthy delay (*Community Mental Health Center of Crawford County: Program Document, 2007*).

In addition, during 2004, the CMHCCC dealt with the growing challenges of working with the Kansas Department of Health and Environment. The growing capacity of the CMHCCC necessitated the licensure of two separate buildings for childcare and this process proved to be quite difficult for the CMHCCC. Because of the two building licensure, there were capacity issues and staff requirements that necessitated additional overhead expenses (*Community Mental Health Center of Crawford County: Program Document, 2007*).

During the 2004 budgetary year, the CMHCCC successfully held an Early Childhood Summit in which 30 persons attended from over 25 area agencies. Out of this summit came productive dialogue around the idea of creating an Infant Mental Health Specialist position, half of which would be funded through Smart Start grants and the other half of the funding would come from the CMHCCC's operating budget. This

position, however, would not be filled until January 2005. In addition, the CMHCCC and Head Start signed a contract to jointly provide Infant-Toddler Mental Health childcare. The creation of admission criteria was an ongoing process between the two organizations, and through mutually considering the mandates that they had to operate by for funding and organizational requirements (*Community Mental Health Center of Crawford County: Program Document, 2007*).

The CMHCCC applied to become a Medicaid provider and that was granted to them during the 2004 fiscal year. They also had the opportunity to increase their organizational capacity to include nursing services by hiring a retired nurse part-time. They were also able to hire a part-time coordinator of senior volunteers, for which they had 15 total volunteers. Together with the department of public health, a public health nurse devoted two days a week to provide Kan Be Healthy screens, immunizations, and general nursing services for young children (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Progress towards goal:

Goal #1—Increase rate of early identification efforts and utilize referral sources;

The 2003 social skills groups remained the same during 2004. Community collaboration reportedly continued to grow stronger (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #2—Increase rate of home placement;

During 2004, 90.4% of children in the program remained living in their homes and did not have to be removed. Families continued to be encouraged to take advantage

of case management services (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #3—Increase rate of Staff and Parents working in partnership;

Parent support services continued to be offered and the program documents indicated a high level of productive interaction between parents and service providers. A family fun night was implemented successfully and it was reported that a 100% of the enrolled families attended the event. It was determined that two family fun nights would be held during each semester, with each event intentionally working to increase the level of parents' participation directly with their children through 'stations' of games and activities (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #4—Increased Parent Satisfaction Rate;

According to the program's report on parental satisfaction, the rates of parental satisfaction reportedly remained high during 2004 (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #5—Increased number of Children entering Kindergarten ready to learn.

The number of children entering into kindergarten who required paraprofessional support was four and only one child required full-time paraprofessional support. Nine children did require an Individual Education Program (IEP). There were no children referred to Cherokee Village. This was unchanged from 2003 (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Identified Barriers

The mental health consultation contract between the CMHCCC and Head Start was reworked during 2004. Reworking the contract was a time-consuming task that took an entire semester. The reworking of the contract led to revised roles and responsibilities for each organization. The downfall of this semester-long process was that no Head Start kids were able to receive mental health services during the entire semester. One of the reported points of friction was the procedural requirements for Head Start. This was difficult for the mental health consultation aspect of the contract in the area of service delivery (*Community Mental Health Center of Crawford County: Program Document, 2007*).

There were continued barriers around issues of funding, defining SED, and diagnostic issues, due to the transitioning difficulties between the DSM IV codes to the DC: 0-3 codes. There was continued dialogue with state officials, regarding funding needs, with little progress made. The relationship between the Kansas Department of Health and Environment continued to be difficult. The CMHCCC made application for an expansion for license to cover the additional building space added through the conversion of the parking garage. The uniqueness of this cooperative program and the multiple overlaying agreements created difficulties for the KDHE to determine the appropriate regulations that the CMHCCC would have to follow. One of the issues was related to the amount of overhead expenses that would be required to maintain two separate licenses. The amount of additional staff necessary for this was cost prohibitive and deemed excessive. Therefore, Michael Ehling consulted with the KDHE representative to determine the best way to move forward. It was decided that an agreement of understanding between Social Rehabilitation Services (SRS) and KDHE

would have to be worked out to move forward. This reportedly would clarify the regulatory issues. As stipulated by licensing requirements, KDHE would not allow any exception for a three to five year old special education classroom (which was under the umbrella of the Interlocal 637 and operated in space owned by CMHCCC). These special education children were not allowed to utilize the grounds of CMHCCC because they were not covered by the license assigned to the CMHCCC. This licensing issue was not resolved during the 2004 fiscal year (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Program Summary 2005

The program experienced significant changes during this year, including hiring additional staff, implementing a new treatment design, and working more closely with parents. During 2005, the staff, as a whole, received a great deal of training to begin implementing the new program-wide family oriented philosophy. The program began making a concerted effort to involve senior citizen volunteers, from the community, to provide intergenerational contact with the children and families through reading, playing, musical activities, and interactive puppetry (*Community Mental Health Center of Crawford County: Program Document, 2007*).

The official documentation (2007) reported that, during this time period, three complete clinical teams were functioning under the supervision of three Qualified Mental Health Providers (QMHP). Qualified Mental Health Providers are:

‘Qualified mental health professional’ means a physician or psychologist who is employed by a participating mental health center or who is providing services as a physician or psychologist under a contract with a participating mental health

center, a licensed masters level psychologist, a licensed clinical psychotherapist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, a licensed professional counselor, a licensed clinical professional counselor, a licensed specialist social worker or a licensed master social worker or a registered nurse who has a specialty in psychiatric nursing, who is employed by a participating mental health center and who is acting under the direction of a physician or psychologist who is employed by, or under contract with, a participating mental health center K.S.A. 2003 Supp. 59-2946(j) (Kline, 2007).

The therapeutic childcare component fully opened during the fall of 2005, during the beginning of November, with one infant and five referrals pending funding through Early Head Start (EHS) or Social Rehabilitation Services (SRS). Through a process of internal review and parental feedback, they created a level of care system. According to official program documents, they reported that they could offer three levels of care:

1. Level One—Therapeutic Child Care for infants/toddlers of Severely and Persistently Mental Ill (SPMI) adults and/or women in Women’s Day Treatment or Intermediate Alcohol & Drug treatment. This included intensive individual and group parent involvement and coaching, home visitation, family therapy, case management, and “mom and me” bonding/attachment groups.
2. Level Two—Outpatient mental healthcare for adults and/or outpatient substance abuse parents who could receive all the above services, except the therapeutic child care.

3. Level Three—collaboration with community partners in a consultation relationship to support existing service delivery systems to parents with infants and toddlers. This also involved staff partnering with Maternal & Infant Clinic staff to provide prenatal support/education/bonding groups (*Community Mental Health Center of Crawford County: Program Document, 2007*).

A Maternal and Infant Clinic was defined as being an income based program that provides such services as: “Primary Care, Preventive Health Care, Physical Exams, Kan Be Healthy Screenings, Social Services, Prenatal and Postpartum Care, WIC Services, Pregnancy Testing, Immunizations, Family Planning, and Teen Groups” (*Maternal & Infant Clinic, 2008*).

As of the fall of 2005, a number of contracts and agreements had been created to help support the goals of the program. These signed contracts and agreements were established in order to pay for the variety of services being provided through the CMHCCC to the community collaborators, with the main funding streams flowing from Social Rehabilitation Services (SRS), Medicaid, and Early Head Start (EHS)(*Community Mental Health Center of Crawford County: Program Document, 2007*).

The CMHCCC then took a significant step forward within their Discovery Infant Mental Health program. They decided to hire a Clinical Marriage and Family Therapist (LCMFT), in order to: provide early childhood mental health consultation services, facilitate training for childcare providers, provide treatment for families, participate on the infant mental health (IMH) project team, and receive consultative services from Dr.

Maldonado (a Nationally renowned child psychiatrist in Topeka, KS), regarding IMH cases (*Community Mental Health Center of Crawford County: Program Document, 2007*). This clinical position was co-funded by the CMHCCC and a local Smart Start Grant, beginning January 2005. A clinical IMH team was also created to include Michael Ehling (LCMFT), the new LCMFT, a case manager, a childcare coordinator, and a nurse. This team was charged with the responsibility of continuing to refine the treatment program and to address IMH issues and concerns as they arose. The two clinical marriage and family therapists oversaw the clinical work, the case manager worked primarily on in-home prevention aspects of the program, the childcare coordinator served multiple roles; one as a caseworker for preschoolers and the other role was to oversee all childcare services. The nurse was responsible for overseeing the medical needs of the both the mothers and the children, and sometimes this meant providing screens, immunizations, and referrals when appropriate (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Progress towards goal:

Goal #1—Increase rate of early identification efforts and utilize referral sources.

The 2004 social skills groups remained the same during 2005. The Discovery Infant Mental Health Program was able to add an additional five Head Start/Early Head Start classrooms to the locations that were receiving these social skills groups (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Community collaboration reportedly continued to grow stronger through the creation of additional community collaboration agreements with RJA, and continued work with SRS. The level of care system reportedly was also an important step to help in

early identification and improved the quality of the response to identified issues or concerns. The hiring of an infant mental health specialist and the creation of the infant/toddler mental health clinical team was a vital step that was completed during 2005 to specifically address goal number one (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #2—Increase rate of home placement;

There were reportedly only 8% of children that received an out of home placement, during this grant period. This was approximately a one percent improvement over the results from 2004 (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #3—Increase rate of Staff and Parents working in partnership;

Continued efforts were reportedly made to continually increase the level of collaboration between the parents and the program. Although there were no official reports dealing with the rate of increase in parental collaboration in the program documentation, there was a personal story reported by Michael Ehling that spoke to this very issue. He reported, in the official program documentation, that he spent approximately eight hours riding in a car with participant families on the way to an Early Childhood Mental Health conference. He reported that,

I had ample time to listen to their life stories and struggles in raising SED children. It was a life changing, both personally and professionally, and was one of several events that shaped an increased responsiveness to families, “a Take It To Them” shift in philosophy and practice, and the creation of CBS (Community Based Specialists) position in the agency that combine psychosocial and case

management functions so that there is a stronger link between group and home with special emphasis on supporting parents to teach and support their children in learn the social skills taught in group (*Community Mental Health Center of Crawford County: Program Document, 2007*).

The program document continued by describing the program's intentional efforts, during 2005, to include parents as a part of the social skills groups, to improve the child's outcome and to more effectively impact the family system as a whole (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #4—Increased Parent Satisfaction Rate;

The program document indicated that there was no official data available for reporting during this fiscal year (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #5—Increased number of Children entering Kindergarten ready to learn.

It was reported that 13 children entered into kindergarten during 2005, four of those 13 necessitated IEPs and one child required full-time paraprofessional support. The rate of referral to Cherokee Village remained at zero (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Identified Barriers

With the identified barriers of 2004 addressed and some measurable progress made, they were ready to take on the challenges in 2005, which were mainly revolving around issues of funding and the need for additional community partners. The CMHCCC and the Restorative Justice Authority (RJA) became collaborative partners and they

worked together to reduce the number of out-of-home placements for infants and toddlers (*Community Mental Health Center of Crawford County: Program Document, 2007*).

The relationship with the Kansas Department of Health and Environment (KDHE) regulations continued to present challenges to the CMHCCC. This year's challenge involved the official distinction of what constituted a "volunteer". This was an issue, due to the fact that some of the parents, involved with the program, had either felony records and/or child abuse/neglect charges against them. According to KDHE guidelines, having individuals with these types of criminal histories was against policy and, therefore, they could not volunteer in the classrooms. The CMHCCC worked to resolve this issue by working with the KDHE to design an agreeable supervision policy for all parents. With the program's intent to be a family focused, it was essential that this barrier be overcome (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Program Summary 2006

During the 2006 grant period, the program's staff received critical training in Conscious Discipline I and II, which was created by Dr. Becky Bailey (*Conscious Discipline, 2007*).

Conscious Discipline is a comprehensive classroom management program and a social-emotional curriculum. It is based on current brain research, child development information, and developmentally appropriate practices. Conscious Discipline has been specifically designed to make changes in the lives of adults first. The adults, in turn, change the lives of children. Conscious Discipline is a way of organizing schools and classrooms around the concept of a School Family. Each member of the family—both adult and child—learns the skills needed to

successfully manage life tasks such as learning, forming relationships, communicating effectively, being sensitive to others' needs and getting along with others (*Conscious Discipline*, 2007).

This social-emotional curriculum did not specifically mention any age in which it is appropriate to start to utilize Conscious Discipline. I emailed Tracey Tucker, Dr. Becky Bailey's personal assistant, to ask her to formally identify the ages for which Conscious Discipline was appropriate. She responded through email by stating,

Dr. Bailey's Conscious Discipline is a social emotional curriculum written primarily for early childhood and elementary school implementation. However, all of the Conscious Discipline skills can be used for your entire life. For example, Composure is the first skill in Conscious Discipline and one of the most important life skills for anyone to acquire. It is the prerequisite skill adults need to discipline children. Composure also helps us in our relationships, when we understand that we own our own upset we are better able to communicate and deal with our own stress (Tucker, personal communication, May, 27, 2008).

The 2006 grant year provided the program with the opportunity also to begin facilitating a monthly staffing for all of their early childhood partners, in order to foster communication and treatment coordination. This monthly staffing was seen as essential to staff of both of SEK-CAP and CMHCCC. One interview participant from SEK-CAP stated that she believed that this provided the SEK-CAP with the necessary interaction and consultation time with the clinical staff from the CMHCCC, in order to work through issues related to both staff level and participant needs. There was an identified need, during this grant period, to incorporate an increased level of intra-agency planning and

treatment coordination between the adult and infant services. The ground work had been established, between CMHCCC and their community collaborators, to best identify avenues to promote early identification of warning signs and the appropriate referral processes between agencies (*Community Mental Health Center of Crawford County: Program Document, 2007*).

This year presented the greatest amount of financial stress when the agency realized the reality of a \$1,000,000 shortfall in certified Medicaid match money, which then resulted in an interagency review of all programs and personnel. As a result of the internal review process, there were a number of employees, agency wide, who had to be laid off. The entire Discovery Infant Mental Health Project was in jeopardy of closing down, due to the CMHCCC's board's concern regarding the negative effects that the downsizing would create for the program standards (*Community Mental Health Center of Crawford County: Program Document, 2007*).

In addition, with the reduction of grant support for therapeutic services to preschoolers, the CMHCCC was forced to reduce their service design and expanded outreach that was integral to the quality and quantity of their mission to preschool aged children and their families. Still, there were accomplishments made during this grant period. The program continued to experience increasing levels of parental participation in psychosocial groups that enhanced and supported their relationship with their child. They also continued to benefit from the 20 senior citizen volunteers' interactions with the families. There was some downsizing of the therapeutic preschool psychosocial groups and other groups were also consolidated into one group. They were able to hire an Early Childhood Mental Health Consultant and began implementing the grant plan. The

therapeutic childcare center continued to provide the same three levels of care as they did in 2005. They also continued the same contracts and agreements that they did during the 2005 grant period (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Progress towards goal:

Goal #1—Increase rate of early identification efforts and utilize referral sources;

The 2005 social skills groups remained the same during 2006. The Discovery Infant Mental Health Program maintained the additional five Head Start/Early Head Start classrooms' providing social skills groups. The integrated classroom approach had reportedly continued to provide opportunities for early identification and referral of young children presenting with SED symptoms. The Ages and Stages Questionnaire-Social Emotional (ASQ: SE) and the KEMPE, had been implemented county wide and throughout most Early Head Start Centers in South East Kansas (*Community Mental Health Center of Crawford County: Program Document, 2007*).

The Discovery Infant Mental Health program staff members were also able to be more purposeful in their attempt to connect more frequently with the adult SPMI and alcohol and drug staff. This was done in order to help the adult staff better understand the concerns to be looking for in pregnant females and to encourage them to be more knowledgeable about what signs and symptoms to look for within the consumers who have young children in their homes (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #2—Increase rate of home placement;

According to the program's record, 93.5% of the families' children who were involved with the program were able to remain at home. The number of families who were receiving case management also increased to further support the goal of higher levels of children being able to remain in their homes. The second half of the grant period revealed a slight decline in the percentage of children remaining in their homes. The in-home placement rate dwindled down to 92.6%. During this grant year, 11.1% of the families had SRS supervision while in the program. The reported out-of-home placement percentage was 7.4 during the 2006 grant year (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #3—Increase rate of Staff and Parents working in partnership;

The program continued to refine the job description of the new Community Based Specialist (CBS) in order to better connect families with the program. This effort focused primarily on enhancing parents' capacity to teach and support their children. The clinical treatment team shifted their standard operating procedure to include the participation of more parents to improve program design and clinical planning. As a supplement to this overarching goal, the program decided to become more purposeful in their efforts to increase father involvement. Due to the collaborative effort, the program began to utilize the Male Involvement Coordinator from Early Head Start, in order to directly address the goal of improving the rate of male participation (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #4—Increased Parent Satisfaction Rate;

The annual parental satisfaction survey indicated that parents continued to be satisfied with the program's services overall. One point of emphasis in the data was that

parents were indicating that they were feeling more capable to manage their children's behaviors (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #5—Increased number of Children entering Kindergarten ready to learn.

Out of the reported eight children entering into the Kindergarten classroom, five of them required an IEP and two required paraprofessional support. The rate of referral to the Cherokee Village remained zero during this grant period (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Identified Barriers

There had been little progress made at resolving the prevention funding difficulties. There were continued funding issues through Medicaid that had been present since the program was initiated. Definitional issues regarding SED also remained a barrier to service. The relationship with Early Head Start became a service barrier, based on their policy not to allow volunteers to be any parents with felony criminal records and this meant that they could not be on the premises of the childcare center. The relationship with KDHE continued to be difficult but there was progress made in the area of the special education children now being able to use the playground on the premises through a special exception.

Program Summary 2007

Due to the continued financial and reimbursement issues, the preschool psychosocial groups were collapsed down into one psychosocial group. The reimbursement issues mainly revolved around narrower guidelines for medical necessity

and guidelines of Head Start and, according to Ehling (2007), this leaves the program only serving the most severe population (*Community Mental Health Center of Crawford County: Program Document, 2007*). During this critical financial time, the board gave a directive to Mr. Ehling (2007), to find additional funding sources within two months or they would have to consider closing down the program. Mr. Ehling contacted SEK-CAP to consider the possibility of contracting for childcare. This agreement was formalized January 1, 2007 and the board approved the program to remain open. This formalized agreement can be seen at Appendix F. Due to the financial crisis, and the new collaboration agreement, the project was renamed to reflect the change and they began operating under the new name of “OPTIONS”. It was the goal of SEK-CAP to replicate this new program in at least two other counties that they serve in their 12 county region (*Community Mental Health Center of Crawford County: Program Document, 2007*). The new partnership with SEK-CAP also provided training and implementation of Positive Behavior Support (PBS) for preschool-aged participants. “PBS has been identified as being an effective practice for preventing and addressing the problem behavior of students in K-12” (Fox, Jack, & Broyles, 2005 p.4). To further define Positive Behavioral Support, I went to the official website for PBS and they defined PBS as:

Positive behavior support is an application of a behaviorally based systems approach to enhance the capacity of schools, families, and communities to design effective environments that improve the link between research-validated practices and the environments in which teaching and learning occurs. Attention is focused on creating and sustaining primary (school-wide), secondary (classroom), and tertiary (individual) systems of support that improve lifestyle results (personal,

health, social, family, work, recreation) for all children and youth by making problem behavior less effective, efficient, and relevant, and desired behavior more functional (*What is School-Wide PBS?*, 2008).

The CMHCCC served 20 families, including 34 children, during this grant period and was able to start a new parent education program at the Renewal House Women's Day Treatment facility (*Community Mental Health Center of Crawford County: Program Document*, 2007). These groups were designed for women with infants and/or toddlers. The CMHCCC continued to iron out the difficulties of working with large community collaboration projects (*Community Mental Health Center of Crawford County: Program Document*, 2007).

Progress towards goal:

Goal #1—Increase rate of early identification efforts and utilize referral sources;

The program increased their outreach efforts to provide 45 hours of consultation services to 30 different childcare providers. They also began extending consultative services to Four County Mental Health and Family Center as they began to duplicate the early childhood mental health service design. The collaboration with Mt. Carmel Hospital yielded 39 women completing KEMPE screens and, of those 39 who completed KEMPE screens, nine were positive for risk factors and yet only one of those accepted a referral for mental health services. The IMH staff continued their interagency awareness efforts with both the alcohol and drug program staff and the adult SPMI staff members. The M & I Clinic continued to be a positive resource for enhancing bonding and attachment for families through targeted activities in groups that are offered (*Community Mental Health Center of Crawford County: Program Document*, 2007).

Goal #2—Increase rate of home placement;

There was a reported 96.6% in home placement during this grant year. The rate of SRS supervision increased from 11.1% in 2006 to 17.2% in 2007. There were no identified factors for the increase in SRS supervision. The out of home placement rate, on the other hand, it decreased from 7.4% in 2006 to 3.4% in 2007 (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #3—Increase rate of Staff and Parents working in partnership;

A special parent feedback session was held to more directly obtain the parent's satisfaction with the program's effort to partner with the families. Eight parents and 21 children did attend the special session. One of the most commonly cited program attributes was the efforts to support parents and also the family therapists going out into the families' homes (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #4—Increased Parent Satisfaction Rate;

The families continued to rate their perception of their ability to manage their children's behavior in a more positive manner. Overall, the parent feedback data revealed that parents continued to be satisfied with the program's services (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #5—Increased number of Children entering Kindergarten ready to learn.

There were 24 children that transitioned into Kindergarten and, of those 24, ten required an IEP and six required additional paraprofessional support. During the 2007 grant year, one child was referred to Cherokee Village, which was the first referral of its

kind since the program originated (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Identified Barriers

This early childhood intervention service model was a self-contained model that was unique in the fact that it combined the Early Head Start center-based model and the CMHCCC's infant/toddler mental health model together. As reported earlier, when working with infants, it is an expensive endeavor. When the grant funding was greatly restricted, the entire model was negatively impacted and required many adjustments to be made to the program, such as consolidating psychosocial groups into one group and decreasing capacity to serve SED children, and thus restricting the amount of billable revenue. The collaboration agreement with the SEK-CAP Head Start and Early Head Start tried to address their federal regulations, which had created adverse barriers to services for the mentally ill parents, especially those seeking to utilize the supports and services through the "Options" program. This was highlighted by the work requirement of 30 hours per week for the parent(s).

"This allowed little flexibility for adapting to individual client's needs for child care, which has prevented a more intensive mental health treatment component to the collaboration, whereby a parent with a high risk infant at risk for removal from the home, can be more closely monitored, receive more hands on feedback regarding bonding and attachment, observe other parents and staff model interaction, and building a support network of parent with young children" (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Participant's Perception and Experience of the Program's Development

The program's development was reportedly an arduous process and there have been a number of transitions and adaptations to the program over time, which were described above. Each participant, regardless of the agency by which they were employed or their assigned duties, had a unique experience and vantage point of how they themselves, the agencies, and the partnerships progressed through the transitions and program adaptations. In the following paragraphs, I am going to utilize the interview data to accomplish the following goals: to shed light on how the program has adapted, how the agencies have worked together, what they saw as the issues that still need to be addressed, and then I will report on how they would like to see the program move forward to address the IMH needs within their catchment area. In the closing paragraph, I will report the unique experience of taking part in this evaluatory process. The themes that emerged will be discussed in the order in which they came during the interviews.

Participants' Initial Perception of Infant Mental Health and IMH Program

I began the interviews with a general question about what their initial thoughts were about infant mental health. The staff all had extensive histories in child development and reported that they understood how important the first three years of life were for healthy growth and development. Several respondents stated that it was difficult to remember what their initial thoughts were because they had been immersed in it for so long now. The entire group of respondents reported that they believed strongly in early intervention and that they were eager to learn about the frontier of infant mental health. They also all reported that they were comfortable with dealing with infant mental health issues. One of the nonclinical respondents said,

Well, I first heard the term about nine years ago, and at first, I was wondering how in God's name would you ever therapize a baby. What did that actually mean? And once I had the opportunity to go to Michigan and speak with the professionals there, I was very excited about it.

I then asked each participant to describe for me what he or she remember about when they first heard about the new infant mental health program that was being created in their catchment area. Two respondents reported that they were not around when the program was first being created but did remember being excited about becoming apart of the innovative program. The other respondents, that were apart of the initial creation of the program, reported being optimistic about it but realized the tremendous amount of work that was before them. Of the common themes that emerged to this question was that of the excitement of working together with other community organizations to best serve infants and their families. One respondent summarized that sentiment well when they said,

Excitement is another thing that I really felt. We had a great opportunity. With Early Head Start, I felt very competent and comfortable that my partners were well versed and ready and prepared to not only take on the challenges but to also to learn from them. And that what I've seen this program do, that we came together to educate each other, to share knowledge that each of us brought to the table, and then collectively adventuring out to discover new knowledge to move forward.

Participants' Perception of Training Background Coming into the Program and the Additional Training Acquired After the Program Started

Each participant spoke uniquely of his or her training backgrounds. Each of them had come from a diverse background that, in some way, included early childhood development or education. The employees from SEK-CAP, across the board, said that they felt very comfortable with their training, coming into the new infant mental health program, but they knew that they were going to require additional training to best meet the IMH needs within the families with whom they worked. Each respondent clearly articulated his or her unique background in early childhood education or development, admitted their training deficit in specific IMH trainings but remained positive about their ability to take on the new challenges that were before them. “I knew that the administrators were going to provide us with great cross training with the partnering agency, so I really was able to just sit back and more or less enjoy the learning curve I was on.”

There was also a consensus about the influential nature of the trainings, regarding the work of Dr. Bruce Perry (who is renowned child psychiatrist and highly recognized child advocate). Administrators, staff, and the program documentation mentioned Dr. Perry as being highly influential and that the staff benefited from attending his trainings early in the program design and implementation stage. Michael Ehling stated also that the visit that he took to San Mateo County Mental Health Center, in San Mateo, California, was helpful to him as he was devising the original policies and procedures for the program. Other trainings that were reported as being helpful in the original design and implementation stage was the family/infant support training in the Children’s Hospital in Denver, CO and also the trainings by Daniel J. Siegel (his medical training is in pediatrics and child, adolescent and adult psychiatry but, he is probably best known for

his work as an author of a number of books about neurobiology, parenting, and child development).

During the initial stages, there was also a great push to get all the staff cross-trained with the knowledge from the partnering agencies and to increase the training within each agency. In some of the interviews, this was highlighted more than others were but it was an important aspect of each interview nonetheless. One respondent reported that:

I trained intensely for; oh, I would say 18 months. I did Touchpoints with Dr. Brazelton. I did Circle Security, the first and second set of that. I did the NCAST training. I went to the national Zero to Three conference. I did First Relationships in Portland and then all the reading of all the literature. . . . I tried to absorb all of that. So, I trained intensely the first 18 months and was out of the office a lot. Probably the most significant part for me, because it was over a longer period of time, was the time spent consulting with Dr. Maldonado. I was able to consult with him for approximately four years, which included regular phone calls and then once a month we met in person. It really helped me put all my pieces together through his consultation. It was difficult at times for me because I had all of this great information and nobody else in the area did, so I worked hard to share the information throughout my interactions in the community.

Participants' Perception of Program's Success

During each interview, the participants would light up when they were given the opportunity to share with me their perception of the program's success. The participants would discuss the program's success as falling within the following categories: their

appreciation of the program's quality leadership and how that leadership was an essential aspect of the program's success in collaborating with other community partners, the program's positive impact on families, and the quality of the team and the trainings that were obtained. I have broken down the results of the variety of different aspects of the program that were listed as being a success by the group of interview participants.

Program Leadership

The participants each directly stressed the importance of there being a person with vision that is leading the way. All but one of the respondents, either by name or by reference, indicated the importance of having Michael Ehling leading the way and sharing his vision with the professionals in the area. The one exception to naming or referencing his importance to the program was Michael Ehling himself. He did acknowledge that it was important to have strong leadership, a strong team, and have a clear vision that is disseminated to the entire team. The quality leadership was also mentioned in regards to Linda Broyles, the Deputy Director of SEK-CAP and the Director of all childhood programs. The partnership and close working relationship between Michael Ehling and Linda Broyles was also cited as setting the tone for the relationship between the two programs and the staff from both agencies. The high degree of teamwork was emphasized throughout the interviews.

Program Teamwork and Community Collaboration

It was stated that the program began as a program that encouraged and worked to facilitate community collaboration and it reportedly has continued in that form today. There was a dissenting opinion shared as to the program's original design. It was stated by a three participants that the original CMHCCC Discovery Infant Mental Health

Program was not designed to be as collaborative as it became and that the program's overall design had been altered significantly. It was reported, by these three participants, that the program was designed to be a community collaboration, in order to create a wrap-around approach to best treat entire families within their catchment area. The current level of collaboration was reportedly a forced issue, due to funding deficits, and this dissenting opinion continued by stating that the current level of collaboration watered down the original design of the program. I will further discuss this issue in chapter five.

Several participants reported that they felt that it was vital to the program's present day success that the administrators began working, from the very beginning, to utilize the staff already inside the agencies, through training and sharing the vision through education in order to build a cohesive unit, and then worked to engage other community partners. This process was stated as being more of a simultaneous process by the two program administrators and was seen as more of a multistep process by the staff members.

The success of this program's design has already been replicated by other agencies. Linda Broyles stated that the program's collaborative design had been replicated with Four County Mental Health and Family Life Center in Cherokee County, which kicked off officially in November, 2008. In order to be able to partner with SEK-CAP, Linda Broyles stated that other mental health centers have to agree to follow the program model from CMHCCC. Michael Ehling and the CMHCCC's staff were contracted to complete mentoring for the other centers through SEK-CAP. She worked with the directors of the programs for approximately one year, on a monthly basis, and she put it into her budget to be able to pay them to travel to the meeting and she reported

that they all came and participated. She was able to share the vision and they reportedly bought into that vision. Then the meetings were moved to occur quarterly. She was allowing monies from her budget to go for her community partners to build capacity, which then directly helped to support her program and further developed the entire capacity for infant/toddler mental health capacity for the region. She also has created criteria for reimbursement rates for mental health professionals to ensure that all providers fully understood infant toddler development in order to be able to work with their population. She also uses SEK-CAP funding for their community partners to complete a three-day PBS training.

Program's Philosophy to Properly Treat IMH Issues

Michael Ehling discussed the success of the program's philosophy to properly treat IMH issues without high rates of medication usage in their zero to five population. Michael Ehling, (2007) stated:

Just as a reference point with our therapy preschool grant, preschool age three to five, we kept stats on that over the years, and there were six grant sites that had therapeutic preschoolers. And we average between seven and ten percent of our children on medications in that age population, compared to one other center in Topeka who had close to 50 – 60 percent of their children on medications. So, as far as a program approach or philosophy, we are not quick to medicate young children. So, we were the lowest grant site and the site in Topeka was the highest grant site as far as use of medication.

There was a consensus reported about the philosophy of the program's uniqueness in that it did address the needs of the entire family. Therefore, it allowed for the

opportunity for better outcomes to occur for the infant and toddler population that they served, and this included working with families and parents that required intensive treatment due to mental illness and/or were recovering from substance abuse.

Linda Broyles believed that the philosophy of the program was able to adapt mental health intervention philosophies for young children and their families from a “swat team” approach to becoming an official extension of the SEK-CAP team. She reported that the mental health providers went from being ‘experts to teammates’. The first year of the program, there were 49 mental health referrals to the ‘swat team’. In the first year that the new PBS training and curriculum was initiated, they only had one referral. She admitted that this was an inappropriately low rate of referrals, because her staff saw the referrals as being their failure to properly operate the new program. The two collaborating organizations reportedly had worked together, with all staff members, to balance the rate of referrals out so that the appropriate use of both programs could be obtained and thus maximize the benefit to participating families.

PBS has been ‘huge’ for their staff to learn how to manage increasingly difficult childhood behavioral problems. On average, one to two students out of each class will need more intensive one-on-one services. She has created a mentoring coach approach to provide additional support to staff. This provided additional support and helped staff in taking incidence reports, so that they have more information to help the team be better able to provide better information for mental health staff.

There is a profound understanding, across staff and collaborative partners, about the intergenerational mental health component. Linda Broyles’ staff consulted with the CMHCCC to create infant toddler center to address intergenerational problems so that it

could all be housed in the same location. Linda Broyles stated that this was Michael Ehling's idea. It was reported that this approach was working fabulously until the budget cuts of 2006. When that occurred on Sept 11, 2006, Michael Ehling called and informed her of the budget cuts and the possibility of having to close "Discovery Infant Mental Health"—now called "Options". She told him that he could not close it.

She then worked with Michael Ehling on an agreement that would allow SEK-CAP to take over the program's budgeting issues and staffing issues, and CMHCCC provided the space and mental health expertise. They had to change some policies and procedures to meet national Head Start standards. Michael Ehling's staff provided weekly staff clinicals for everyone to stay on the same page. The agreed upon design was reportedly a seamless agreement between organizations to properly train staff and treat young children and their families in their own homes or in the clinic-based option. She reported that the mental health professionals were involved in all of their activities, and she believed this level of involvement had greatly assisted families and staff not to have the negative stigmatism against mental health.

Program's Positive Impact on Families

Each of the participants seemed to have a favorite story of success of how the program positively affected a family. Multiple participants mentioned one family as being a typical example of the program's success. The following story was the illustration that one of the participants gave of their perception of what the program's success meant to this one family but it reportedly could have been the account of any number of families who took part in the Options program.

This is one example I can think of right away, of how I have noticed changes in families after taking part in this program. We had a mother that initially had two children. She was actually ready to give birth to her third child when she entered the Options program. At that time, it was Discovery. Her oldest son was now placed with other family members. Her daughter and she had not connected and we were worried, and now here is this other child. Right. And that's a person we had been able to work with in a home-based setting, but you're talking an hour and a half a week. I was able to watch her progress through multiple children. So, what we saw was, she's one person that we saw that was able to have conversations with her daughter during mealtime, which was unbelievable because, before, she would have put food on the table and walked away from this two and a half year old and not even thought anything of it. Then when her child was born, she saw staff holding and rocking her son, her new son, and so we started placing her in the chair and pretty soon, she felt very comfortable. She was just walking around her home one evening during one of the visits and I got a call from a staff member right after that because they said, "you won't believe this." She picked him up without even thinking and began to sing to him and was giving him eye contact and was touching his cheek. Something we had never seen her do with her other children. So that's how we saw it begin to translate because it became, even though it may be more initially a habit, it was a positive habit. So you are just hopeful that those new behaviors become ingrained. You know, like innate behavior. She did, later, have another child, we saw it again, being in the

center, that child's life began the way you want it to, with that bonding, which previously she would not have known how to do.

This story provided an example of how the staff members were able to identify the positive influence that their work, through the program's unique design, was having on the families, which they served.

Perception of Key Characteristics of Program Staff

An important characteristic of the staff, which was already employed by the agencies, was the awareness of the importance of a systemic view of families. The two clinical marriage and family therapists, on the CMHCCC staff who were leading the way, championed this view and the remaining staff had extensive trainings in working with children and their families and adopted the systemic lens quickly. Michael Ehling believed that it was essential for staff to have the following characteristics in order to be success operating within this program:

A good attitude, some body that can think strengths based and obviously, some competencies and knowledge base around development, families, and relationship skills are very important. Someone who thinks naturally about families. I think it takes a lot of adaptability and a lot of understanding because the rate of development and the window to intervene is so narrow. Really, when you stop and think about it. You have to have someone who is decisive but extremely patient.

Perception of Key Program Components

The program had a number of unique features that, reportedly, helped it to be successful in addressing infant mental health issues in their specific catchment area.

Michael Ehling believed that the program had a solid team structure that depended on everybody's bringing his or her unique contribution forward to the rest of the team. The IMH program had worked to avoid barriers imposed by HIPPA regulations, especially for sharing information between programs and organizations. This had been a major aspect of all program planning. The level of program collaboration had been difficult for the organizations to overcome, especially when it comes to having one single employee's salary split between two separate organizations. One such position was the clinical professional, infant/toddler mental health specialist, which was employed by SEK-CAP and CHMCCC. This professional stated that a key program component was the consultative role she provided. She elaborated on that by saying,

So, if a childcare provider has a concern about a child in their classroom or childcare setting or if they're home providers, I'm able to go out and coach that provider to do things more interactive or to assess that child. If we can't get the symptom taken care of there, then I go ahead and consult with, go ahead and talk with the parent and see what it is, what we're doing, what they're doing, what does that look like, getting everybody on the same page of the concerns of the infant. With that status, it's let me identify a few children early at work that needed diagnosed, spectrum children or even birth through services or speech services or those kinds of things. Consultations are a huge piece. I'm also called to doctor's office if our OBG has a client that's been smoking marijuana or mental health concerns, or if she's just got a red flag for, or if the pregnancy is not right. I show up at the doctor's office and work with the client, right there in the office. As a consultant, I go to the hospital if there has been a new delivery and

mom has not held the baby yet, those type of clients. So, that's a big chunk of what I do. Also, consultation to the Head Start Infant Center. When I do consultations, they become open charts and clients, either on the infant or the parent. Initially we only open on the parent, but now we've gotten braver and open on the infants. That's been no problem; everybody's just scared of it.

Linda Broyles talked with me about the key components and one of those components was its "strengths-based" focus. She believed that "strengths-based" focus was a reflected vision within her own staff. The key program components, according to Linda Broyles were as follows:

Passionate leadership, constant open conversation among staff members, a tool kit is housed at each site location that employees can use beginning with their orientation process. It is important that all staff understand how critical this model is to everything else we do. Therefore, reminder materials are on the wall, give members of the team ownership. Monday morning messages—positive encouragement, reinforcing message, giving bits of research, training, assignments to be working on, scaffolding training, and how to teach children social emotional development. Reflective supervision is provided for every staff member, regardless of how long the employee has been here. This is provided by the direct supervisor. Everybody has a professional development plan in order to keep up on what they feel they need additional support.

Uniqueness of the Zero to Three Population within this Catchment Area

I asked the program staff and administrators about their perception of the uniqueness of the zero to three population within their Catchment area. Michael Ehling stated,

It is probably the historical stuff between rural and urban in terms of just distance and accessibility. There are not as many services available and the typical rural issues of transportation, poverty, etc. play a significant role in how we plan service delivery. I think the isolation probably tends to be more pronounced because you tend to get these adults who pocket themselves out in these far little towns in the far reaches of the county. That's one reason they go to these communities is for isolation. This then breeds its own kind of issues. They tend to be more isolated from a larger community even though they are in a smaller community, especially if you throw in the drug factor, it's the nice marriage for the two factors (isolation and drugs use and manufacturing). This isolation also allows them to be away from the watchful eye of law enforcement and other oversight people.

There were a number of staff members that reported that they felt that, although the catchment area was rural, the actual zero to three population was not any different from young children living in any other catchment area. There were no opinions expressed that articulated a specific uniqueness for the young children living in their catchment area.

Participants' Perceptions of the Barriers Facing the Collaborative Efforts and Partnerships

The participants, who were involved in the early stages of program's development, shared with me their memories of there being some bumps along the way in creating the program as it stands today. It was amazing to me that each respondent that stated this as fact, never once referred to the 'bumps' in a negative manner. They would quickly disagree with me if I inferred a negative connotation to the bumps by saying, "I wouldn't say that it was negative, I would simply say that it was a learning process that everyone was positively invested in seeing the same product in the end." Another respondent articulated their view using a rural analogy,

You know if you have a rural background, and you know what it is like to start up a huge motor or a huge combine, or a harvesting mechanism. When you start the first pulley belt and then the rest of them gradually become engaged, it was like that. I've always thought you had to start small and then it built and built and built until you got your motor running smoothly or you got your machinery running smoothly. We at least had gotten that pulley belt going and we were starting to see the simple parts of the machinery starting to become engaged. I was on a steep learning curve myself. And then try to impart some of that knowledge in a helpful way to other health professionals was obviously a big step that had to be worked with when we first started out.

There was a common barrier expressed, the element of the unknown. From the perspective of half of the SEK-CAP employees interviewed, it was difficult at first to refer families to the program because they didn't have a clear understanding of the program, so they weren't entirely comfortable with it. There were two members, from each agency, who stated that there were significant issues facing the new program and

one of issues repeatedly mentioned was the fact that the program was strictly a voluntary program. Because of the voluntary nature of the program, it was mentioned by two participants that it was frustrating, early on especially, when their desire for families to be involved exceeded that of the families themselves.

Several staff, from both agencies, reported that they didn't see the program as using the "carrot or the stick" approach but, rather, they worked to encourage families to see the potential benefits of participating in the program. I was surprised by the staff's reports about how they felt that families were following through with the mental health referrals with a high rate of success. In three out of the four interviews of SEK-CAP employees reported the high rate of families' following through on referrals to the mental health program. The main reason that I was surprised by these statements was that, during the course of my interviews, I had heard several comments about how the program was frequently seen by parents as being 'adversarial'. This was an apparent contradiction, in my mind, because if you see an agency or program as being adversarial, it was my thought that the families wouldn't want to become more involved with it. So, I then asked a follow-up question to each participant. I asked them to explain the apparent contradiction. One respondent clarified it well by saying, "Yeah. Some families do still see us as being tied with SRS, but that fades quickly. Those families don't want us in their homes all the time, so a center-based option is welcomed by the majority of families."

Several staff also expressed initial concerns, regarding what the parents' responses would be to the program and how confidentiality would be upheld during the program's activities and more specifically the psychosocial groups. This was an early

obstacle to overcome, in order to ensure the success of the program's activities. One staff clearly stated those concerns by saying:

How do you keep the confidentiality? How do you make sure that staff respect that and not carry that out? How do you get the parents to respect each other's need for confidentiality? How do you help parents feel comfortable and not like they are in a fish bowl with everyone watching their every move?

The majority of interviews contained a discussion about how the two collaborating programs shared the same vision of the preferred outcome for the participants but each respondent was able to state that there were some stark philosophical differences about how to accomplish the end goal. Multiple interviewees stated that they felt that the federal regulations of the Head Start organization were "too strict with their guidelines and with such rigid guidelines. It didn't allow for the needed flexibility and some staff didn't initially understand the need for flexibility with the targeted population." Participants from both organizations reinforced this point. Another aspect of the philosophical differences, between the two organizations, was reportedly how similar concepts could be viewed so differently by two partnering organizations. The number one example, reported by participants from both organizations, was the concept of self-sufficiency. Self-sufficiency was seen, by SEK-CAP staff, as being seen as:

One of our main focuses is on self-sufficiency and goals and unless you understand mental illness and how that affects people you, it's not always, you know, "Pick up your boot straps and just get over it and move on." These families aren't capable of doing that. That's where mental health came in and educated us. But then I, sometimes I think they're, and this is my opinion, sometimes I think, I

don't want to say, it's like, not coddle, but they do more for the families than, you know, we're about supporting but, you know, "You make the phone call." We're standing here beside you to make that phone call. I think sometimes the mental health staff were doing everything for the families, but each family is a unique case and so you have to. I think that's why the teamwork was so important, because you have to know what the mental illness is and what's driving the behaviors. So, a lot of insight but I think we have had some butting of heads just because we're coming at it at from two different angles.

Through an employee from CMHCCC, it was reported that it was seen by CMHCCC as being:

Self-sufficiency speaks to 'they can do it'. I would probably call it survival. I mean, if I had all of those skills that you want me to have, where I can be self-sufficient, I would not need your services. Often times, the mental illness, or the lack of being able to keep things together, excludes us from services because I can't keep an appointment at two because I can't keep an appointment at two. And so you have not shown up for four appointments, therefore, you must not be interested in our service. If I could get organized enough to make your appointment, I wouldn't need your service. It's that, that's the barriers I think, helping the people understand. And mental health, in adult services, we work hard to get our clients to that level of organization. I think individuals can do that with some people, but you throw a child on top of that and that is enough disorganization to mess with anyone's regular time of day. For us, that's why we are home-based. That's why as mental health staff, we get very frustrated when

we hear things like ‘this or that was not being done by this parent.’ My thought is she’s mentally ill. She’s mentally ill, okay, let’s act surprised.

Through these conceptual conflicts, staff from both agencies stated that there needed to be ongoing education and training to keep everyone on the same page. It was stated that, if everyone was on the same page with concepts, then it would be easier to work through the stressful differences.

The staff members didn’t mention the administrative barriers that were present, such as the contractual issues between agencies, state and federal regulatory issues of the Kansas Department of Health and Environment and with Head Start requirements. When asked about why this was, one administrator stated that they worked to insulate the staff from these issues so they could simply focus on their work with infants and their families.

The administrators spoke about the same barriers that were mentioned in the program documentation, which made sense to me, since they were the authors of the program documentation. One additional barrier that the administrators spoke of, that was not covered by the program documentation and the staff didn’t mention, was the difficulties of finding applicants that had the skill set needed to perform the clinical duties within this program’s structure. They have had to fund all the additional training to get employees up to speed with the latest trainings. One administrator stated that the program was fortunate that they have been able to retain the same clinical employee during the early years of this program. Therefore, it was reported that their training dollars had to be well invested. If training dollars were not well invested and they were not able to retain the employees into whom the training was being poured. One administrator stated that,

It would be impossible to find someone who has the required skill set due to the lack of comprehensive training, in the area of IMH within the current university programs.” They would more than likely suffer a significant program set back if they lost their clinical staff member and had to spend time training someone else to take over that position. This model is intense and requires specialized skills and when students graduate from college, they don’t have the skills that are needed. That creates a huge learning curve. Some are adaptive and others are not. Skills that lacking include understanding of the unique model, not understanding the complexity of families, their expectations for how everything is going to work. Then when entering a therapeutic classroom, they don’t have enough training in classroom management and behavior management to successfully operate within this program. Then we have to teach them the skills that we consider basic and essential. They don’t know enough about working with parents and families coming out of college so we have to train new employees in these skill sets as well. Turn over has been an issue due to teacher frustration over children’s challenging behaviors. They don’t understand how to talk with parents about their children in supportive manner, reinforcing positive behaviors.

Another issue that the administrators spoke about, that the staff members did not, was the lack of financial stability. Administrators were reportedly continually pursuing funding from grants and other community-based funding opportunities. It was reported that the administrators spent an enormous amount of time working to stabilize the program’s finances and this restricted their capacity to directly participate in the daily activities of the program. The funding issues were reportedly critical to the program’s

forced adaptations, most specifically the transition from the Discovery Infant Mental Health Program (which was under the direct control of the CMHCCC) to the now called Options Program (which is directly under the control of SEK-CAP). This transition of ownership reportedly had a significant impact on program staff, especially those who were a part of the original design process. This difficult transition of program ownership will be further discussed in chapter five.

The rural treatment barriers, which were discussed in chapter two, were also reported during the staff and administrators' interviews. As a review of those rural barriers, here is brief list of those barriers: a paucity of qualified professionals, both medical and mental health practitioners, which left rural communities with increased difficulties in identifying and treatment IMH concerns. To add to those barriers, I will provide an overview of rural barriers by utilizing the following quote:

Stress, due to factors associated with geography such as isolation and transportation problems; as populated by a large number of undereducated, poor, and unhealthy people; as associated with a higher than average prevalence of psychiatric disorders, especially depression, and severe intergenerational conflict. ...rural values are holistic, that functioning in the community is the "social yardstick" of mental health and that distinction between physical and mental health are seen as artificial, and that helping in rural communities is very different from urban helping (D'Augelli & Vallance, 1981 p.3).

Perception of the Future Direction of the IMH Program

Each interview participant was given the opportunity to provide his or her view of the future of the program. The participants each discussed their idea as to what the

program needed to do in order to become better and more successful. I am now going to break up this subsection into the five most commonly occurring responses.

Decreased Staff Turnover at SEK-CAP

Three staff members reported that there needs to be less staff turnover at SEK-CAP. It was reported that, because of the rate turnover, the program's vision has not been able to be consistently passed down from leadership to staff. One participant was able to summarize how they themselves and the other two staff would address this turnover issue by saying,

How? Well, I would like to say money would be apart of that. Nevertheless, I think it's not just money. It's being able to work with the local university to be able to somehow to develop an infant/toddler mental health/early childhood degree kind of a combination would be something I think would be helpful because that would prepare people for what they are going to see.

Returning to Original Program Design

It was reported that anytime you lose focus of the original goal or design, you allow the program to drift. It was stated that, "whoever holds the money, holds the power" and those that hold the money now have "diluted the original design and the program has reverted back to more of the childcare approach and older ways of doing things". Multiple participants acknowledged this and there were those who referred to this with a more negative tone and others that simply stated this as fact in a neutral fashion. Multiple staff members, from both agencies, mentioned that they felt that both programs worked hard to make the difficult transition go as smoothly as possible. There was a sense of loss reportedly experienced by the CMHCCC staff when the program

changed hands but they were happy the program was able to continue to stay open and serve as many families as they are able to still serve. One participant stated that he or she felt that CMHCCC became “more in sync with concepts that were learned from Early Head Start (EHS), and EHS increased their conceptual understanding of families.” Members of both agencies’ staff reported that they were richer for the collaboration and happy the program is still open. “I think it’s serving a lot of the same people we would be serving. I do think we are missing some people that are not being served because of the complexities of their funding, their goals, and their policies.”

One of the participants spent a great deal of time discussing this issue of what he or she felt was the “diluting” of the original design. This next quotation explains his or her perception of how the program’s approach was “diluted” over time. In order to capture their perspective and experience, I am going to include their quote here.

When we had the funding available, we were working with the parents, as well as the children, not only birth to three but, birth to five as well, which encompassed all of the Discovery Program. We were seeing great improvements. We were seeing a lot of changes. We were seeing many positive results from our efforts. Just as soon as the money started to dwindle, Discovery, in an effort to stay going, took a multi-fold approach. The first things that we saw happening was that personnel, who were well-seasoned personnel here, were let go. Why those people were let go, I don’t fully know. Then you get in people who are not as educated or experienced and not as in tune with the program. Then as the funds became even tighter, the Discovery Program tried to say, “what can we do to continue the program so we don’t have to shut the whole thing down.” First, they engaged with

USD 250, the school district here for the 3-5 year olds. Okay. They said, “we’ll provide the physical plant and we have staff working here who are already engaged with this here and you put up the monies.” Therefore, when they put up the majority of the monies then they want to take over the control and how things are run. What happens when you refer a child out to a program for uncontrollable mental health and/or behaviors and you can’t anymore because they are disrupting the classroom, of the program, that they are referred to for help? What happens to the therapeutic approach to the child? The same thing happened with the infant program. Now, when Crawford County set up this program for zero to three, they knew that it would not be a money making project, because of the diagnoses doesn’t hold any official ranking for mental health reimbursement until age three. So, they knew that anything that the program dealt with had to come through the parents. Okay. And as things became tighter and tighter and the policies changed, the instability increased, such as who was eligible and who wasn’t and what treatment are we going to get reimbursed for etc., etc., that all shut down. Therefore, they said, okay, we’re going to try to get together with Early Head Start. Okay. They approached it the same way as they tried to do with USD 250, as far as we have the program, we have the staff here and we need you put up the monies.

Once the agreement was established, along comes Early Head Start with over 2000 policies. The Discovery Program had mandated that parents come to the center and be there at least part of the time, because we were teaching parenting skills, and teaching them about how to engage with their child. They were

working with them, both the parents and most predominantly mostly the mothers. They were working with parents to help them with their issues while, at the same time, working to change different aspects of their parenting to be able to work with their child better. That approach seems to have changed. It shouldn't happen through a "what is your mental illness or what are your abuse issues," because there were different agencies to work with those issues. The connection there was, for Discovery, it was always the relationship focus. The Early Head Start parents always had to be in a job or going to school. That was the first glaring difference. There were some naming issues occurring but at any rate, it became known as Options. By the time I left the program, the program got to what I call being, very much water downed. We were down to a childcare center, not therapeutic really. If those little babies, who had come in showing physical and emotional signs of having problems right away as a newborn, those little guys are now going to have a much harder time of making it through and getting straightened out.

Increased Number of Clinically Trained Personnel

There was a consensus, among interview participants, in regards to the perception of the need for additional clinically trained personnel to address the IMH concerns within their catchment area. These additional staff would reportedly be utilized to be more fully integrated in the classrooms, be placed at the local hospital, and be more available for consultations and interventions.

Creating a Third Classroom and Special Parent-Child Space

There was a visionary statement made about how a third classroom would greatly benefit the program's objects. It was stated that:

I think we need and would benefit from maybe a third classroom that would just be in addition to what's happening now because there is merit in assisted childcare for a child. But the part that I miss is having, is that drop-in-ability. So, if a kid had been picked up and put in state's custody and the issue is hygiene and care, then rather than what happens now, which is those people are given a list, go to parenting class, we're going to hold you, we're going to take your baby and put them in a foster home and you're going to go get a job, you're going to go to a parenting class, which will be some verbal regurgitation, you're going to keep a job, you're going to keep a house, and then we're going to give your baby back. So we give a baby back six months later and the baby's six months older and has more issues with the parent than the first place. So, my wish in life is that there is some place where that parent can come into services with that child. So, that we would in some type of setting be with that parent as they learn to bath and cloth and feed and run them through daily routine kind of cycle and so that it's parent education and a practical and applicable kind of thing. And, in addition to that, there needs to be a place where baby can be and momma and dad can just go take a break.

Improved University Curriculum Focused on IMH Training

It was reported that it would be nearly impossible to replace the clinical staff member who is currently working for the CMHCCC and it was stated that the lack of focused university curricula have significantly influenced the turnover at SEK-CAP. It was said that, there is not a university program available that trains SEK-CAP staff to uniquely deal with the entire family system, such as working directly with parents.

Therefore, when the new staff enter their classrooms and are dealing with mental health issues in their students, they are not equipped to properly respond to the student or to their families in manner that optimizes the outcomes for the child. There were several staff who discussed the lack of applicable university training programs available for therapists to be trained to address IMH directly or within the greater family context. It would be a tremendous asset to have MFT programs incorporate more IMH issues and for more child development programs to include a greater MFT understanding. Since IMH is so interdisciplinary in nature, no one discipline takes the lead role, or ownership, in the design of a comprehensive IMH program. Therefore, in order for staff to work in this collaborative program, it required a high rate of program dollars to be allocated for their training to get them up to speed. This takes time and is risky when you invest thousands of training dollars into an employee and then, if they move on from the program, you have to start all over again.

Dr. Murray (2008) stated that, “there is talk of the University of Minnesota creating an online certificate program. This might serve to at least acquaint staff with the academic information that they lack about attachment, successful intervention approaches, and other topics for example,” (Murray, personal communication, November 2008). This program, if it does become a reality, could further support the Michigan 4-Level Endorsement System for IMH and could help rural programs, such as the “Options” program receive the needed ongoing quality training without the expensive travel.

Interview Experience

I invited each interview participant to explain their thoughts and feelings about being interviewed by someone outside of their organization. Each participant appeared to be open and cooperative with his or her responses to this question and there was a consensus response. That consensus was that they have discussed this program so much with community partners that they have become accustomed to explaining the program. They also added that they were “excited about the opportunity to share their thoughts about the program.” There were five respondents who stated that, by talking about the program’s development, it was like a stroll down memory lane and also provided an opportunity to focus on the program as a whole, instead of just completing daily tasks. Three participants also discussed how the interview experience had helped them to refocus and how it rejuvenated their passion for their work. There was a consensus that they would have said the very same things about the program, regardless of whether I was from the organization or an outsider. As one participant stated, “We are very forthright with our opinions around here. I have told you my thoughts and feelings and I would have said the very same things to my boss as well, and in fact I have already done that.” The overall sentiment was positive about being interviewed but one participant did note that,

It makes me very sad to talk about it because I don’t have the opportunity to try to move this forward. Because of budget restraints, I am no longer able to be a part of the team. I couldn’t have had any finer treatment from the agency. But to not be able to help in any way now is sad because I still have the desire and there’s still a need here for that particular passion and help.

My Experience with the Interviews and Data Collection

In this brief section, I would like to take the opportunity to share my thoughts and feelings about this data collection experience. I would be remiss if I didn't admit that the data collection process was a lengthy journey that included collecting the program's official documentation, completing the interviews, and then working to attain an intimate knowledge of the findings from the collected data. The program documentation had never been compiled together into one document, prior to my inquiry. The documentation was complete but it was not put together, due to the reported daily duties of the business. I found the documentation to be a complete and thorough review of the developmental process of the program. The administrators were very cooperative in their efforts to make their agencies' staff and program documentation as available as possible to me for the purposes of this project.

Throughout the interviews, I found myself experiencing a range of emotions from sadness to sheer excitement. The sadness was examined and found to be seemingly derived from multiple points of origin. I will discuss these points of origin as a part of the Executive Summary in Chapter 5. The participants, from both organizations, were delightful to talk with about their experiences and it would have been easy to extend each of the interviews into the second, third, or fourth hours. However, due to time constraints, I had to work hard to restrict conversation to the semi-structured interview guides. I found only one participant to be quite guarded during the initial ten to fifteen minutes of the interview. Upon reviewing my field notes, I questioned my internal experience during the actual interview but then noted a definite change of tone of voice of the participant as we entered the final three quarters of the interview. I am uncertain as to the nature or

origin of this guardedness but I have been resigned to thinking that nervousness and awkwardness of the proceedings would be the leading causes this participant's apparent guardedness. At the conclusion of the interview process, they reported that they were comfortable with the interview process and the opportunity to review their own journey with the program's development. I inquired as to their experience of talking with someone from the outside and they said that, "I would say what I have said to someone on the inside or the outside. I don't get to do this very often, but I think most people know what my opinions and what my passions are."

It felt good to give each participant the opportunity to give voice their personal journey in the program. It was exciting to see their faces light up when they shared their experiences with me. When they were sharing their vision of what they would like to see in the future of the program, it left me feeling secure in the fact that infants, toddlers, and their families really had a strong group of passionate advocates who will be working hard for them for a long time, provided funding holds up.

Chapter 4 Summary

The analysis of the interview transcripts and program documentation allowed for the proper illumination of the program's developmental process and a view into their current operation. It was clear that everyone, who took part in this study, recognized the value of the each agency's strong leadership and the importance of having a visionary leader like Michael Ehling. It was through his provision of the model for staff and agency's collaborating relationships that forged the template for all others to follow.

There was ample evidence of the program's growing pains, especially in the following areas:

1. Difficulties with the cooperative agreement with SEK-CAP involving struggles in attempts to mutually meet each agency's standards on both the local and federal levels;
2. Funding limitations with a growing identified target population;
3. The Kansas Department of Health and Environment's regulations for capacity of the facility;
4. The internal growth process, of both agencies, as they were trained to better understand the new design and the roles that were going to be played out by each participant, which created difficulties in dealing with individual staff member's comfort level with the program.

The difficult growing pains continued with the question of how to assist staff as the transformational process continued, not only through policies and procedures but also through structural changes to their facilities. There was significant confirmation of the negative impact that the financial instability created for the program's design and for the perception of program's ownership from a staff member point of view. There was clear evidence for continued support of this program's design. Even though there is a moderate level of disagreement about how the program's design has been negatively impacted by the financially forced adjustments that were made, there remained a positive sentiment among all staff participants about the benefits of the overall impact the program has on families.

CHAPTER 5 - Discussion

The purpose of this study was to explore the important lessons learned by the Community Mental Health Center of Crawford County (CMHCCC) and their community collaborator South East Kansas Community Action Program (SEK-CAP), so as to further inform the fields of Infant Mental Health (IMH), Marriage and Family Therapy (MFT), and Community Mental Health Centers (CHMC), in order to:

1. Illuminate the process by which CMHCCC created a new approach to treating IMH concerns within the infant, his or her family, and the greater community context, and ask how it had been operationalized during the first two years of service delivery,
 - a. Discover the organizational and procedural barriers, through the in-depth staff interviews, to assist the CMHCCC and their partners in their continued effort to provide high quality services,
 - b. Better inform policy makers and financial decision-makers of the early signs of the positive effects of such services, and
 - c. Gather feedback on the usability of a collaborative approach to addressing IMH concerns within a collaborative community mental health center approach, which could help lead to other CMHCs replicating the model within their catchment areas.

This study's exploration yielded a clearer understanding of the developmental process of the infant mental health program and its initial implementation. My study utilized a formative program evaluation approach, in order to gain an understanding of how the program was designed, the goals of the program, the barriers that they faced, and

a provided unique look into the experiences and perceptions of both administrators and staff members, of the developmental process and its implementation. A formative evaluation allows a researcher to take a comprehensive look into the targeted program's design and provide stakeholders feedback, regarding the initial program's implementation by illuminating the areas of the program's design and/or implementation that are working well and those areas that need improvement (Patton, 2002).

A thorough review of the literature revealed a paucity of research, regarding the topic of designing and implementing a systemic infant mental health program, that was carried out through a rural community mental health center in a community collaborative manner. The literature established the need for additional programs, designed specifically to treat the infant/toddler mental health concerns within the infant/toddler and their greater family unit. Once the literature review was completed, it was apparent that there were gaps present (within both fields of IMH and MFT) in available treatment approaches that utilized a systemic approach to address the IMH issues. Through the review of the relevant literature, it also was clear that rural community mental health centers were without a model for a systemic and community collaborative approach to treating infant mental health concerns. Through my conversations with the infant mental health program's director, Michael Ehling, in 2005, it was evident that the program that he had been designing, was working to uniquely address the identified gap in the literature. It was at that time that I became determined to further investigate this program's openness to being further evaluated for the benefit of research for the fields of both infant mental health (IMH) and marriage and family therapy (MFT), and to provide valuable feedback for the possible improvement of the program's design and/or

implementation. The program's stakeholders (Michael Ehling, Director of the CMHCCC Discovery Infant Mental Health program, and Linda Broyles, The Assistant Director of SEK-CAP and Director of all Childhood Programs) agreed to participate in the evaluatory process and I carried out the designed evaluation project.

In the next section, I will provide what Patton (2002) calls an *Executive Summary*. This is a report that aims to be brief and accessible to those for whom it was intended, the stakeholders. Executive Summaries also are intended to more narrowly report the findings than the exhaustive review found in chapter 4. It is important to note that, as Rossi et.al (2004) stated, "Program circumstances may change between the initiation of the evaluation and its completion in ways that make the evaluation results irrelevant when they are delivered" (p.91). This being said, the purpose of this formative evaluation and its findings extend beyond the targeted program itself. As stated previously, the aim is basically two fold: first and foremost to evaluate the targeted program and, as a secondary byproduct, will help inform the fields of IMH and MFT in order to asset future program designers implement similar programs in their catchment areas.

Executive Summary

Carrying out this formative program evaluation included a thorough review of the relevant literature from the fields of IMH and MFT and gaining a contractual research agreement with the participating organizations (CMHCCC and SEK-CAP). The evaluation process also included receiving IRB approval from Kansas State University, completing seven interviews in person and one interview by phone with personnel from the CMHCCC (4) and SEK-CAP (4) organizations, drawing down and analyzing the data

collected from the interviews, formally presenting the results to both organizations, and then successfully defending the dissertation project at Kansas State University.

Through my thorough review of the eight interview transcripts and program documentation, it grew increasingly clear that the value of the program's positive impact on families outweighed the perceived hassle of getting the "belts of the machinery running smoothly." The uniqueness of the rural context was addressed through the program's design and reported implementation by assisting families with transportation, providing opportunities for home or center-based service options, and through the utilization of staff who were already familiar with the agency's vision and the uniqueness of the targeted population. These measures were consistent with what the literature believes is essential in rural areas in order for a program to operate successfully (D'Augelli & Vallance, 1981; Elwell, 1970; McPheeters, 1977; Stamm et al., 2003; Watson et al., 1999).

Core Program Components

In effect, there are a number of core program components, which the Discovery Infant Mental Health Program, now called Options, provides for the catchment area.

These components have three levels of focus:

1. child and family,
2. program,
3. community & catchment area.

These core components are: Assessment, intervention, linking, care coordination, and consultative services. The program provides these services through the following systems of care approach:

- Three levels of care:
 - Level One—Therapeutic Child Care for infants/toddlers of Severely and Persistent Mentally Ill (SPMI) adults and/or women in Women’s Day Treatment or intermediate alcohol and drug treatment,
 - Individual and group parent involvement, coaching, home visitation, family therapy, case management, and mom and me bonding/attachment groups,
 - Level Two—Outpatient mental health adults and/or outpatient substance abuse parents who can receive all the above services except the therapeutic child care,
 - Level Three—collaboration with community partners in a consultation relationship to support existing services delivery systems to parents with infants and toddler.
 - Partnering with Maternal and Infant Clinic/hospital staff to provide prenatal parent support/education/bonding groups (*Community Mental Health Center of Crawford County: Program Document, 2007*).

- Contracting Agencies:
 - SEK-CAP: purchasing child care slots,
 - SRS: childcare provider agreement,
 - SRS Purchase of Services: individual Parent/Group Education as well as Family Support,
 - Medicaid provider through Part C for service coordination,

- Mt. Carmel Regional Medical Center and Crawford County District
Hospital #1: voluntary infant screening by OB staff.

Program Strengths

The program's current operation was found to have been adapted from the original operating design. Although the program's design was not reportedly operating in its original form from 2003, the interviews did reveal that it was currently (2008) being carried out in a manner consistent with program's stated mission. The strengths of the collaborative effort, which were identified in the program documentation and in the interviews, to work at addressing the IMH concerns, within the catchment area of the Community Mental Health Center of Crawford County (CMHCCC), were as follows: strong program leadership, sound program design that addressed IMH concerns within the family context, persistent efforts for community collaboration, provision of center and home-based treatment options, and the provision of ongoing staff training. This program recognized the relevancy of the bi-directional nature of influence, between the family members of all ages. The bi-directional influence was also identified between the family and the contextual variables, that present themselves to families, such as the availability of community resources, economic hardships facing individuals and families, and the impact of adult family member's alcohol and drug addiction or their unique mental illness has on the infant's mental health status and developmental possibilities. The pictorial nature of this bi-directional influence was depicted in the Ecological Map that I created in chapter two of this document.

There was a consistent correlation for the program's accomplishments, between the official program documentation, and that which was reported during the participant

interviews. Those accomplishments included success in each of the five stated program goal areas.

Goal #1—Increase rate of early identification efforts and utilize referral sources;

In 2003, The Discovery Infant Mental Health Program was able to provide social skills groups in the community with SEK-CAP Head Start and USD 637 Interlocal. This integrated model included three early childhood special education classrooms in two elementary schools and one family resource center. This provided community outreach in a manner that was reportedly highly successful. The program was committed to the idea of disseminating their vision for infant mental health throughout their catchment area and that dissemination effort began in-house. The program completed cross training efforts with partnering agencies and all related program staff received the essential training. An important aspect of this process was assisting adult care workers, for both mental health and drug and alcohol, in better understanding IMH issues.

In 2005, the Discovery Infant Mental Health Program expanded their outreach services by adding two more Head Start/Early Head Start classrooms to the locations that were already receiving these social skills groups during 2003 and 2004. Then in 2006, the KEMPE and the Ages and Stages Questionnaire-Social Emotional (ASQ-SE) began being implemented countywide, and throughout most of the Early Head Start Centers in South East Kansas. Utilizing these standardized measures across the catchment area, provided a common base of education and training for all professionals who work with this population. Throughout the program's development, they worked to increase their training in assessments and interventions, in order to pursue the highest degree of early identification possible.

In 2007, the program continued to increase their outreach efforts and was afforded the opportunity to provide 45 hours of consultation services to 30 different childcare providers. They also began extending consultative services to Four County Mental Health and Family Center as they began to duplicate the early childhood mental health service design. The collaboration with Mt. Carmel Hospital yielded 39 women completing KEMPE screens and of those 39 completed KEMPE screens, nine scored positive for risk factors and yet only one of those accepted a referral for mental health services. The M & I Clinic continued to be a positive resource for enhancing bonding and attachment for families through targeted activities in groups that are offered (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #2—Increase rate of home placement;

In 2003, the program documentation reported having fewer than 15% of children in their ‘Discovery Infant Mental Health Program’ removed from their homes. They were successfully linking more families with the program and the homes of the families through the increased usage of case management services. The rate of out-of-home placements consistently declined from 2003 to 2007. There was only one exception, which was during the 2006 grant period. During this time, the percentage of participating children being able to stay in their homes dropped by one percentage point and then returned to an increased rate during the 2007 grant period. There was no official reported understanding of the reason for the slight drop during the 2006 grant year. However, the percentage of drop was not statistically significant, dropping only from 93.5% to 92.6%, and then it continued to rise during next grant period. The only reported program change, during this grant period, was that the Early Head Start policy regarding volunteers. The

policy would not allow any individuals, with a felony criminal record, to be allowed on the childcare premises. This could have restricted some of the at-risk parents from participating in the program and possibly could have influenced the slight decline in the rate of in-home placements.

During 2007, there was a reported 96.6% rate of in-home placement during this grant year. The rate of SRS supervision increased from 11.1% in 2006 to 17.2% in 2007. There were no identifiable factors for the increase in SRS supervision. The out-of-home placement rate, on the other hand, decreased from 7.4% in 2006 to 3.4% in 2007.

(Community Mental Health Center of Crawford County: Program Document, 2007).

Goal #3—Increase rate of Staff and Parents working in partnership;

In 2003, the program reported greater cooperative efforts in partnering together between the program and the parents. The program's team also got together as a staff and developed goals to improve outreach to parents. These outreach goals were not enumerated within the program's official documents. Although there was no officially reported cause for this, it was my expectation, that in 2003, the program was in the planning phase and this was not an implemented practice until possibly in 2004. In 2004, a family fun night was implemented successfully and it was reported that a 100% of the enrolled families attended the event. It was determined that two family fun nights would be held during each semester, with each event intentionally working to increase the level of parents' participation directly with their children through 'stations' of games and activities.

The program continued to refine the job description of the new Community Based Specialist (CBS), in order to better connect families with the program. This effort focused

primarily on enhancing parents' capacity to teach and support their children. The clinical treatment team shifted their standard operating procedure to include the participation of more parents to improve program design and clinical planning. As a supplement to this overarching goal, the program has decided to become more purposeful in their efforts to increase father involvement. Due to the collaborative effort, the program began to utilize the Male Involvement Coordinator from Early Head Start, in order to directly address the goal of improving the rate of male participation. A special parent feedback session was held to more directly obtain the parent's satisfaction with the program's effort to partner with the families. Eight parents and 21 children did attend the special session. One of the most commonly cited program attributes were the efforts to support parents and also the family therapists going out into the families' homes (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #4—Increased Parent Satisfaction Rate;

The program handed out satisfaction to all parents and encouraged parents to give the program feedback. The program's documentation reported that between 2003 and 2007, parents rated the program's services as 'very good'. The parents indicated that their ability to manage their children's behavior in a more positive manner continually improved between 2003 and 2007 (*Community Mental Health Center of Crawford County: Program Document, 2007*).

Goal #5—Increased number of Children entering Kindergarten ready to learn.

This goal is a reflection of the presence of zero to three programming. Children who had ongoing and yet undetected mental health issues were more likely to enter school requiring additional educational and/or behavioral supports. The identification for

the need of Individual Education Program (IEP) services presented an interesting question to me. Was the number of IEPs a reflection of the program's success? An increasing number of children were being identified as needing IEP services from 2003 through 2007. Was this the result of the program's failure to properly prepare children for kindergarten? On the other hand, was it a sign of the success in the early identification efforts being made by the program? I posed this question to Linda Broyles (2008) and she said,

In my opinion, the increase in IEPs is a result of more children being indentified at an earlier age...exactly what we want! In the past, many children would show up in the 3-5 program, or even in Kindergarten, with special needs that could have been diluted or even extinguished with early care and intervention. We have PUSHED hard to find the children who really need services and have also referred them for additional services, which has increased numbers. I think that the increase in numbers is directly related to earlier identification, which I would identify as a huge success. We have also worked diligently with Part C to streamline our referrals process, in order to more quickly identify needy children (Linda Broyles, personal communication, 2008).

I agree with her perception of the situation. When more professionals are aware of the early warning signs, it only makes sense that more children would be identified as meeting the criteria for additional services. The challenge ahead for this program seems to me to be related to how the program impacts those that are identified early. What difference does it make in the treatment process? What difference does it make for Kindergarten readiness? Overall, does it improve school performances of those identified

children when they reach first, second, and third grades? My impression is that yes. They are ahead of where they would have been if they had not been identified until Kindergarten. Those studies fall outside of the scope of this evaluation project, but they create some great questions in my mind.

I asked Linda Broyles what happens to the IEP criteria once the child reaches school age. She responded by saying,

When the child transitions to the public school, a new set of criteria is used to identify need. A paraprofessional is assigned if a child requires one-on-one assistance or if a classroom has too many special needs children. If that is the case, additional staff is required to be assigned to that classroom. Often times Part B does not have adequate staff to meet the need, and tries to group children with similar needs together to deliver the services (Linda Broyles, personal communication, 2008).

Starting in 2003, and running through 2006, there were no referrals made to Cherokee Village, which is an alternative behavior disordered school. In 2007, the first child was referred to Cherokee Village (*Community Mental Health Center of Crawford County: Program Document*, 2007).

The strengths and benefits of this collaborative program were highly evidenced in the program documentation and in the participant interviews. The two data sources maintained a high rate of correlation. Although there was a significant positive sentiment override for the program and its design, there were difficulties reportedly facing the program from the creation of the program to the present date. A positive sentiment

override simply denotes that there is enough positive regard to outweigh the presence of the negative, therefore leaving a more positive influence than negative (Gottman, 1999)

Difficulties Facing the Program

A common thread, identified in the interviews and program documentation, was the difficulties of creating a program's design that specifically addressed the mental health concerns of infants/toddlers and their families; through periods of economic instability without, as one participant phrased it as being "diluted," which was described previously.

It was apparent to me that, due to the reported funding issues, the program, and the staff within the program was forced to make a difficult adaptation to the manner in which the program functions on a daily basis and this was reportedly hard for staff from both agencies. After reviewing the program documentation of the yearly summaries, I expected to hear a lot of negativity in the perceptions during the staff interviews. Nevertheless, the participants didn't directly speak of this transition experience as being excessively difficult but further reflection upon my field notes revealed a number of references to the difficult challenges that faced the staff from both agencies. I attribute this reporting as being a result of the administrators, from both programs, shielding front line staff from the administrative hassles they were going through, in terms of creatively blending funding, coping with the loss of funds, coping with policy difficulties and other contractual complications with KDHE.

There was an understanding among staff members that the level of community collaboration was necessitated, especially during these economically strained times, but the appropriate level of collaboration needed to properly treat the target population was

reportedly still up for debate between partnering agencies. The program's leadership was reportedly "exceptional" at providing the staff with regular doses of the program's overarching vision. I attribute the ongoing debate about the level of collaboration needed to this program's staff having a passion for being correct in how they operate.

Throughout the interviews, I got the sense that, above all else, they were passionate about meeting IMH needs through this program and they were not afraid to voice their opinions about how they felt the IMH needs could be best treated. This openness is apart of the modeling that was provided by the program administrators, Linda Broyles and Michael Ehling.

In my field notes, I also identified the sense that I had during the interview process that the participants were reflecting to me their picture of the transitional process, and that picture appeared to be blunted by the amount of time that had passed. There was a hint of bitterness from three CMHCCC participants, due to the reported forced nature of the transition of the program's ownership from CMHCCC to SEK-CAP. This was seen as something to work through to accomplish their goal.

The funding shortfalls reportedly caused more than the difficult transition of the program's ownership, the shortfalls also created limitations for the program's capacity to carry out the original program design. Two staff members directly reported, and one alluded to, the fact that they felt that the original program design had been lost and, in order for the program to return to maximum benefit to infants and their families, program ownership needed to be "recovered" by CMHCCC. This seemingly was a philosophical issue, as the CMHCCC staff, who voiced their desire to regain ownership, did so with the intent to get back to the original design and implementation. In their view, the original

design and implementation was centered more on the clinical aspects of IMH: prevention, assessment, and intervention and less on the strengths of the SEK-CAP program. The SEK-CAP staffers didn't share those same thoughts and yet pointed to fact that they desired additional funds for the CMHCCC so "they could get back out in the community with a stronger presence." The apparent program ownership tension resided more heavily on the side of the CMHCCC, especially among staff members. The program administrators reportedly maintained an open and honest dialogue about these issues and that approach has continued to the present day. It remained unclear if the extent of clear communication among staff was replicated to the level of success that the administrators experienced.

Recommendations

The evaluation results, which have been drawn from the program documentation and the semi-structured interviews, have led me to make the following recommendations for program consideration:

- ***Leadership and Vision:*** The strong program leadership has been a key asset for the reported early success of the program's design and implementation. In order to perpetuate this as a program strength the following additions should be considered: providing additional opportunities for the leadership to be in front of program staff, possibly holding more joint agency meetings, where program leadership could be openly sharing their continued vision and be actively problem solving with the staff from both agencies. This could potentially boost staff members' internal confidence in the program's direction. This commonly shared

vision and confidence in the program would add to the ongoing reliability of the program's design and mission, by further ensuring all staff members are pursuing the goals and doing so in the same manner. These additional opportunities would be an addition to the weekly clinical meetings that are apart of the program's current design procedures.

- ***Program Clarification:*** With the reported turnover, within the SEK-CAP staff, it would be beneficial to have a refresher course on the program's core mission. This would provide a consistent understanding, across both programs, as to how the program's mission is to be carried out on a daily basis. This would ensure that all staff members were on the same page, regardless if they had just recently joined the staff or have been around the program since 2003. This would not eliminate the difficult staff turnover issue, but it would maintain the consistent program message.

The concerns about staff turnover should not be seen as a fault in program design or as failed leadership. Staff turnover is a reality in the world of early childhood programs. In response to my concerns about staff turnover, Linda Broyles stated that,

All early childhood programs have a high degree of turnover. A rate of 20% is not uncommon. It is difficult to retain staff due to low wages, long hours, challenging behavior, unresponsive parents and an unrealistic view of what the job would be like! College does not prepare educators for the rigors of early education. Infants, toddlers and preschoolers require a good deal of care and a large dose of patience. Children do not come programmed to do what they are

asked to do. They have to be taught. When they cannot talk, we teach. When they cannot walk, we teach. But, when they do not know how to behave we...typically discipline instead of teach. That is our society! Many early educators get burned out because they cannot stand dealing with challenging behavior or with what they term 'bad kids'. They do not know the difference between a bad child and bad behavior, and therefore they take the acting out personally. Teachers sometimes feel that they cannot do what they set out to do which was to teach, because they are always dealing with challenging behaviors. They do not understand child development, especially social emotional development. This is HARD work! We have designed ways to provide additional support for new staff during their first year in order to help them avoid feeling incompetent which is at the core of many cases of burnout. The other thing that happens, when someone leaves a position, is that others have to pick up that caseload until a new person can be hired and trained, because we have to keep enrollment numbers at 100% in order to maintain our funding! That is a hardship for everyone. Additional work tends to sacrifice quality for quantity! The twenty percent staff turnover rate does raise some questions about continuity of care for participating families. This continuity of care issue is outside the scope of this particular study, but it needs to be more closely examined through future research efforts.

- ***Collaboration Consultations:*** This issue resonated for the SEK-CAP staff through their desire to obtain more of the “pearls of wisdom” from the clinical personnel from CMHCCC. Continuing the practice of an on-going clinical sharing group would maintain a bi-directional information sharing and would continue to ensure a high level of staff collaboration for the benefit of all staff and quality outcomes for participants. This sharing is reportedly occurring to a small degree now but it was mentioned during five of the interviews that this sharing, could be improved through more on the sport staff-wide sharing instead of simply sharing the “pearls of wisdom” to the closest educator or staff person. The issue that I see with this is that there is some role confusion occurring in the clinical team member that has transitioned in a role from seeing themselves as a direct service specialist to more of a consultant role. They stated, “When it’s a consultant’s roll you have to observe things, make suggestions, and then step back and see what happens next.” I heard this as role confusion. I also understood the SEK-CAP staff as requesting a more hands on consultant. It would be beneficial for both agencies, together, to create a shared picture of what this consult’s role is and how this role would function out on a daily basis.
- ***Community Building:*** There was a call for increased community outreach through strengthening clinical consultations with SEK-CAP and other community agencies. One example of this could be to increase the effectiveness of the current consultations through utilizing more frequent,

on-the-spot sharing, by the clinical observers. This current strength could be made stronger. This is, in large part, a funding issue. How do you continue to do more with less money? This requires further evaluation as to resource attainment and distribution. How can the program bring in more money and/or allocate more funds to this particular area of the program's operation? Until additional funding is secured, a more detailed look is warranted into the process by which the clinical staff observes the different settings and makes their observations and recommendations known to requesting community agencies and community partners.

- ***Training:*** One participant stated that “additional funding doesn’t solve everything; we have to continue to be able to find qualified staff members ready to come in and meet the challenges at hand.” It was also reported that, if the clinical team member were to resign, retire, or leave the position for any reason, the program would “lose thousands of training investment dollars that we could ill afford to replace.” From the interviews, I derived a few potential options to address these identified issues.
 - An increased connection with local university program decision-makers is required. This program has the fortune of having two strong leaders guiding the way that do an exceptional job of creating strong community relationships. The program also has two, now former, employees who are well-respected college level educators who have incredible passion for this program’s purpose,

design, and personally feel called to serve the program in any way they can. Is there a way for these two well-respected individuals to connect with the key decision-makers within local university training programs, to further educate them about the “real world” requirements of properly treating IMH concerns? This could provide for an exciting academic frontier for both MFT and early childhood degree programs.

- The second option is to have the standard of the Michigan 4-level endorsement system be a requirement for all employees who work for the “Options” program. The State of Kansas has joined Minnesota, Arizona, Texas, Oklahoma, and New Mexico as the only states in America to be granted an Infant Mental Health Endorsement program (Murray, 2007). Below you will find a figure that illustrates the Michigan 4-level endorsement system, which explains the training components required and the capacity to which each category of endorsement can serve (Murray, 2007). The Michigan 4-level endorsement would be a valuable asset for the “Options” program to utilize as a standard for training the professionals working for both agencies.

Figure 5-1 Michigan 4-Level Endorsement System (www.mi-aimh.org, 2008).

MI-AIMH LEVELS OF COMPETENCY				
	Level 1	Level 2	Level 3	Level 4
	Infant Family Associate	Infant Family Specialist	Infant Mental Health Specialist	Infant Mental Health Mentor
Educational Degrees earned	CDA or Associate's Degree	Bachelor's or Master's Degree	Master's or Post-Graduate Degree	Master's or Post-Graduate, Doctorate, Post Doctorate, or MD
Work Experience	Two years in the infant, early childhood and family field	Two years in the infant, early childhood and family field	Two years post-master's work in the infant, early childhood and family field	Three years post-master's work in the infant, early childhood and family field
In-Service Training	30 Hours	30 Hours	30 Hours	30 Hours
Signed Code of Ethics	Yes	Yes	Yes	Yes
Reflective Supervision/ Consultation	N/A	Minimum 24 clock hours within a one to two year time period	Minimum 50 clock hours within a one to two year time period	Clinical: Minimum 50 clock hours within a one to two year time period
Written Exam	No	No	Yes	Yes
Service Examples include but are not limited to the following jobs	<u>Promotion</u> Childcare worker, play group leader, Doula	<u>Prevention/Intervention</u> Home visitor, Early On service coordinator, NICU nurse, parent educator, childcare consultant, child protective services worker, ISS/MSS staff	<u>Intervention/Treatment</u> Mental health clinician/supervisor, infant mental health specialist, clinical nurse practitioner, lactation consultant, early intervention specialist	<u>Leadership</u> Infant and family program supervisor, administrator, researcher, faculty member, policy specialist, physician

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MI-AIMH

Limitations

This study is limited in its generalizability to broader populations, due to utilization of only one distinct population sector being served by one particular community mental health center. The targeted populations to receive the services through the community collaboration, under the umbrella of the Community Mental Health Center of Crawford County, were women within the CMHCCC catchment area, who were pregnant and who were currently suffering from psychiatric disorders, or who had been identified as having substance abuse disorders. It is also limited by the narrow scope of the evaluation design. Since this is a formative evaluation, my main focus was on the formation process and not the initial clinical outcomes, satisfaction of clinical population in services, or the impact the services were having on the prevalence statistics. There was a retrospective nature to the interviews. The program director began creating the program outline in 2003, and the interviews were conducted in 2008. By asking individuals to recall events and experiences from the past lends itself to the possibility of the participants' not accurately recalling the all the information. This could include examples of not remembering dates or transitions made that have now been replaced. It could also occur when the staff went through so many changes at one time, that the events that now are regarded as being less significant, at the time, could potentially be lost among all the other changes being made.

Future Considerations

This particular research provides a needed bridge for both the fields of Infant Mental Health and Marriage and Family Therapy. The need for this bridge was identified after extensive review of existing literature, within both of these fields. There was

significant evidence that spoke about the need for additional work to be done in the area of creating programs to treat the IMH concerns within a systemic context, which properly accounts for and works to properly address the mental health concerns within the entire family, in order to provide better clinical outcomes for everyone involved. This program did provide evidence that there was significant benefit to its design and implementation strategies. This research project could provide for multiple directions for further consideration.

1. First, this project proved to be useful and effective within this particular catchment area's targeted program and population. There was reportedly another CMHC that was working to replicate this program's design. It could be quite beneficial for an additional review to be completed on that program, to see how that program is fairing early in their implementation efforts. It would be helpful to review the participants' experiences of replicating this program within their catchment area and to identify similarities and differences between the two programs. This additional study could also provide valuable information on how to improve the program component's generalizability to other geographical areas and populations. This would allow the staff variable to be further clarified, which, to me, means that it would provide the opportunity to distinguish between influences of the program's components and that of the program's staff.
2. Secondly, it would be helpful for both partnering agencies and the respective fields of IMH and MFT, to be better informed about the clinical outcomes, and have a better understanding of the program's participants, over a longer period

of time. This could help develop a greater knowledge base about the clinical effectiveness of a systemic community collaborative infant mental health program. Researchers, within both fields, are currently pushing for empirical evidence for both clinical effectiveness and efficacy statistics.

“Efficacy refers to, the results of a systematic evaluation of the intervention in a controlled clinical research context. Considerations relevant to the internal validity of these conclusions are usually highlighted (p. 1051). ...Effectiveness has to do with the applicability and feasibility of the intervention in the local setting where the treatment is delivered. Efficacy studies emphasize internal validity and replicability; effectiveness studies emphasize external validity and generalizability (p.1055)” (Barlow, 1996).

3. Research Examples:

- a. One example of a potential research project that could come from this study is the idea of an efficacy study involving the consumers of this program. In this study, the consumers could have the regular intake process occur, with all the standardized assessments completed. Then the child could be tested again for change markers at critical developmental points as he or she is tracked through the program. This could create baseline data for the children entering into kindergarten. This baseline could be tracked and compared as the child goes through the first, second, and third grade school years. This could provide important longevity information for both the fields of MFT and IMH. This study could use the principles of developmental psychopathology as its guiding framework. I

would also be interested in tracking the family dynamics, such as parental awareness of their child's emotional cues and their ability to respond to those cues, from the intake date through the third grade as well. This could provide some rich information on the family change process within at-risk families that are dealing with IMH issues.

- b. Another example would be for the program to evaluate the impact that staff turnover has on the continuity of care. This issue could be examined over a two to three year plan that purposely evaluates the policies and procedures for staff replacement. This would help identify any gaps in services and help identify ways to streamline new staff hires and help illuminate the impact staff turnover has on patient care and child outcomes.
4. This study provides the necessary knowledge base for both effectiveness and efficacy research to be completed in the future. This study was able to have a comprehensive literature review, of both fields IMH and MFT, all within one document. This literature review could be utilized to help increase awareness of the educational deficits within both fields of study. I believe these educational deficits are identified as MFTs not having enough training in IMH issues, assessments, or interventions. Remember, out of 173 family therapists surveyed by Korner and Brown (1990), approximately 86% of respondents excluded children in therapy more than 75% of the time. They went on to conclude that approximately 40 percent of the surveyed therapists never included children in the treatment process (Korner and Brown, 1990). This study revealed that, when

therapists feel that they have sufficient training in working with children, they are more inclined to work with more children as clients. The field of IMH has some barriers to face before a college curriculum could be improved upon. With the multi-disciplinary nature of this field, no one really has taken the lead role in providing a college degree program for IMH. The University of Minnesota is rumored to be working toward an online certificate program and my hope is that they will be diligent to include some of the wisdom from the MFT literature in their curriculum.

a. I understand that MFT training programs are already composed of stringent requirements and the graduate programs are not interested in creating an entirely new curriculum filled with IMH studies. Therefore, I would recommend the addition of a few key components be added to MFT training programs:

i. Within the typical developmental course that is required, include an additional section focused on the youngest population, infants. My experience with curriculum is my review of two distinctly different MFT training programs and their developmental courses are quality courses but, due to time constraints, and emphasize the early developmental years is lacking. If even two class periods could be utilized for the mental health needs and concerns of this population, clinicians would be more comfortable interaction with these young children, and families overall would be better served. This could be an opportunity for MFT programs to reach out to

IMH professionals and they could come in and teach these two courses.

- ii. The difficulty of adding information to the IMH field is that no particular discipline has taken the lead with the instruction and credentialing of professionals as far as a masters or doctorate in IMH. There is the Michigan 4-Level Endorsement System and there are rumors of an online certificate program beginning through the University of Minnesota. It would be important for the all IMH credentialing efforts to take advantage of the opportunity to reach into the field of MFT to gain the wisdom from them.
- b. It would be ideal to review the present attitudes of university program directors to determine their willingness to add IMH training to the MFT curriculum. In that same vein, it would be interesting to further evaluate the IMH's educational movement and determine the level of systemic understanding is included in the training programs.

Concluding Remarks

This formative evaluation was useful in evaluating the *Options* program's rich developmental history and in gathering the experiences and perceptions of the program administrators and staff. In a time where the research field is pushing for more effectiveness and efficacy studies, it is essential to first understand if the program is implementing the design as it was created to do so. My study aimed to create that understanding. This evaluation revealed that, although the program has some internal and

external challenges facing it, it is operating through an adapted design that remains committed to carrying out the program's mission.

It is my hope, that the results of this evaluation study have provided, both program administrators and staff, the opportunity to reflect on how they do what they do. In addition to that, I trust that it has illuminated a few key areas, which can be addressed, to keep this program meeting the IMH needs, within the CMHCCC catchment area; and that it can be widely replicated by other CHMC in similar environments.

Appendix A - Kansas State University

Informed Consent Form

PROJECT TITLE: A Formative Evaluation of a
Systemic Infant Mental Health Program to Improve Treatment for Infants and Their
Families Through A Rural Community Mental Health Center

APPROVAL DATE OF PROJECT: _____

EXPIRATION DATE OF PROJECT:

PRINCIPAL INVESTIGATOR: CO-INVESTIGATOR(S): Corey D. Schliep LCMFT

CONTACT AND PHONE FOR ANY PROBLEMS/QUESTIONS: 785-532-1488

IRB CHAIR CONTACT/PHONE INFORMATION: Rick Scheidt, 1 Fairchild Hall, KSU, Manhattan, KS
66506, 785-532-3224

SPONSOR OF PROJECT: Kansas State University

PURPOSE OF THE RESEARCH: To learn more about how the systemic Infant Services Program, for
infant mental health, was originated and operationalized within a rural
community mental health center to more effectively treat infant mental
health issues within the infant and their families.

PROCEDURES OR METHODS TO BE USED: Participants will be asked to participate in an interview in a one on one setting by this investigator, that will last a minimum of one hour and a maximum one and a half hours. If there needs to be a follow up interview, the participants will be contacted and given the opportunity to continue to participate if they chose to do so. If a participant choses not to continue to participate, the researcher will terminate contact with that participant with the appropriate debriefing statement.

All interviews will be recorded through digital audio technology, the information will be collected and reviewed by the investigator, and all information including digital audio recordings, and written responses will be maintained in a locked cabinet with only the primary researcher having the key.

ALTERNATIVE PROCEDURES OR TREATMENTS, IF ANY, THAT MIGHT BE

ADVANTAGEOUS TO SUBJECT:

If a participant identifies that they do not want to be recorded through audio equipment, the participant can select to write out/type their responses to the researcher's questions. If this option is selected, the participants will be asked to identify this preference when they sign up for the interview.

LENGTH OF STUDY: This is a dissertation study that will last no longer than three months.

RISKS ANTICIPATED: By participating in a dialogue between individuals that may have different views, the potential exists that disagreements could occur. We will not release your contact information to any of the other participants, and there will be no direct

contact between the participants. The participants will also have the ability to select how much information to give out about themselves.

BENEFITS ANTICIPATED: Participants will be assisting in the process of creating an increased dialogue between two mental health fields that will potentially further the information base and the resources that are available to both fields and in the long term will benefit the children children under age three and their families. This study could also benefit other rural mental health centers by informing them about the creation process for infant mental health services, which could result in additional community mental health centers developing more successful treatment for infants and their families.

EXTENT OF CONFIDENTIALITY: All names and contact information will be kept anonymous. All data collected will be maintained in a locked cabinet at all times, with the primary researcher controlling all access to the stored data. With the limited amount of subjects, there is the potential that some answers may indicate the author of the statement to the readers of this study. In an attempt to protect participant(s)' identities, I will only use direct statements that have been approved by the author of the statement.

IS COMPENSATION OR MEDICAL TREATMENT AVAILABLE IF INJURY OCCURS: The appropriate referral sources and contact information will be provided upon the completion of each interview. This is designed to assist the participant in seeking the appropriate source, of professional help, without the added inconvenience of having to contact this researcher.

PARENTAL APPROVAL FOR MINORS: No minors will be participating in this study.

TERMS OF PARTICIPATION: I understand this project is research, and that my participation is completely voluntary. I also understand that if I decide to participate in this study, I may withdraw my consent at any time, and stop participating at any time without explanation, penalty, or loss of benefits, or academic standing to which I may otherwise be entitled.

I verify that my signature below indicates that I have read and understand this consent form, and willingly agree to participate in this study under the terms described, and that my signature acknowledges that I have received a signed and dated copy of this consent form.

(Remember that it is a requirement for the P.I. to maintain a signed and dated copy of the same consent form signed and kept by the participant

Participant Name:

Signature

Date

Witness to Signature: (project staff)

Signature

Date

Appendix B - Interview Guide

(Administrators)

For Program Director Only

1. Please describe your professional credentials?
2. What is your current title?
3. How long have you been in your current position?
4. How many clinicians does it take to properly operate the infant toddler program?
5. How many clinicians do you currently have?
 - a. How many are licensed Marriage and Family Therapists?
6. How many support staff does it take to operate the infant toddler program?
7. How many support staff do you currently have?
8. Do you utilize caseworkers for the infant toddler program?
 - a. If so, how many caseworkers do you employ?
 - b. How are they utilized to supplement the clinical program?
9. Do you utilize medical personnel in the infant toddler program?
 - a. Nurses? If so, how?
 - b. Psychiatrist? If so, how?
10. When did you first get the idea to start the infant and toddler mental health program through Crawford County Community Mental Health Center?
11. How long did it take from that date to propose the program plan to the CCCMHC administration?

12. What was the most difficult obstacle to overcome between the time you had the idea and when the program had its first day of operation?

13. How long did it take to create the policies and procedures for the new program?

14. Did you have a theory or model that you used to guide your efforts? Yes No

a. If so, what theory did you use?

b. If you had a guiding model, what is the model and is it being used somewhere else currently?

15. Please describe the most difficult obstacle to overcome in creating the program design?

16. Where does the infant and toddler mental health program obtain the majority of its funding? Please rank the following options from the highest percentage of funding to least percentage of funding for your agency

A. Federal Programs____ **B.** State Programs ____ **C.** Local Program____
D. Not for Profit Organizations ____ **E.** Other please specify

17. Does your program qualify for any grants on the state or federal level?

a. If so, what is the percentage of your program's annual budget that comes from grants?

b. How often do you have to reapply for your grants?

- c. How did the program address this obstacle? Explain.
- d. In your opinion, has the obstacle been successfully worked through?
Explain

18. How have you worked to partner with the community?

- a. Was the partnering with the community vital to provide successful treatment to the program's participants? If so, please explain.
- b. If the answer was no, please explain.

19. What obstacles have you faced in partnering with other community agencies?

20. Did you face any negative stigmatism while creating your program? If so, please explain how the program addressed the negative stigmatism and were the efforts successful?

- a. Did you face any negative stigmatism during the first year of operation? If so, please explain.
- b. Do you currently face any negative stigmatism

21. Please describe what skills are required to work in your agency, specifically within the zero to three program?

- a. What skills, if different, are essential to be prepared to successfully complete the clinical duties with the zero to three population?
- b. Are these skills available in most job applicants that you have considered hiring for this program? Please circle one answer Yes No
 - i. If yes, please explain where you look for most of your applicants?
 - ii. If no, what skills do you find lacking most frequently?

22. Did you face any difficulties in finding applicants? If so, please explain.

23. Please indicate the number that best applies to your agency.

a. Are most of your job applicants:

1. Recent graduates from a master's level program?

a. If so, what type of program? Psychology, Marriage and Family Therapy, Social Work, or other?

2. Master's level therapist that have worked in their respective fields for awhile?

i. If so, how many years of work do they have with the zero to three population on average?

3. Recent graduates from a Ph.D. level program?

a. If so, what type of program? Psychology, Marriage and Family Therapy, Social Work, or other?

4. PhD level professional that has worked in their respective field for awhile?

i. If so, how many years of work do they have with the zero to three population on average?

24. Of the applicants that you would consider hiring for a clinical position, what skills do you think that they lack that are considered necessary to be successful working in your program?

- a. Do you provide this training in-house after hiring of the applicant or do you pay for those you hire to attend training out side of your agency after the hire?
25. Did your agency face any difficulties in training clinicians to work in the infant toddler program? If so, please explain.
26. How did the program overcome those difficulties? What barriers do you see facing the program in being able to successfully provide services to the zero to three population within your catchment area?
- a. In your opinion, how has the agency addressed these barriers?
27. What barriers do you see facing families, in your catchment area, from being able to obtain your services? Please explain.
28. What barriers do you see hindering successful treatment of IMH issues?
- a. How has the agency addressed these barriers? How have you addressed these barriers?
29. What do you believe are the most important successes?
30. In conclusion, do you have any other comments that they want to make about the program?

Appendix C - Interview Guide (Staff)

The following is a list of the initial questions that will provide probes for the interviews. If the research participant does not automatically offer at least one specific example, I will be asking for one to illustrate their thoughts and ideas.

The following questions are about your experience in the creation of the program.

[Use follow-up probes to clarify their role in each question below]:

1. Please state your name for the record.
2. What is your current job position?
 - a. What are your main responsibilities?
3. How long have you been in your current position?
4. What is your license?
 - a. How long have you had that license?
5. Do you remember your initial thoughts when you heard the term infant mental health? Please explain those thoughts.
 - a. Once you initially started working in the infant mental health program, how did your thoughts about infant mental health begin to change? Please explain.
6. Do you remember your initial thoughts when you heard about the infant mental health (IMH) program? Please describe for me those initial thoughts.
 - a. Once you started working within the IMH program, how did your thoughts about the infant mental program change? Please explain.

7. When you were initially hired by the program, how comfortable did you feel to directly deal with IMH of the zero to three population? Which of the following responses best represents your comfort level. Please explain.

Very	Uncom	Neutra	Comfor	Very
Uncomfortable	fortable	1	table	Comfortable

8. Please explain your comfort level of directly treating the IMH concerns with the zero to three population, at the time of your hiring into the new program.

9. Prior to working for the infant/toddler program at CMHCC, had you worked with the zero to three population in a clinical manner? If so, explain.

10. How competent did you feel when you were first hired by the program to provide direct treatment services to the zero to three population and their families? Please explain.

Very	Incom	Neutra	Compet	Very
Incompetent	petent	1	ent	Competent

11. Please explain why you felt that you were at the competence level that you circled in the previous question.

12. Did you seek additional training as a result of your competence level? If yes, what kind of training and where. If no, move to next question.

13. Did the program coordinators conduct mandatory training for all staff on how to clinically treat the zero to three population and their families? If yes, ask 12A and

12B. If no, ask question 13. Please describe the training, i.e., what was the name of the training, what did it teach you.

- a. Please describe how this training impacted your level of comfort and your level of competence.

14. Please explain what you feel is the most difficult aspect of clinically addressing IMH concerns.

15. The following questions are related to your perception of the treatment program components at CMHCC?

- a. What are the main treatment components of the program?
- b. Is there a treatment philosophy or theory that guides treatment? If yes, please explain.
- c. What treatment modality is most frequently utilized by you? Individual, parent-child, or family therapy?
 - i. Please describe your most commonly used treatment modality? Do you believe this is the same for the other clinicians in the program?
 1. Who attends the sessions?
 2. Where are the sessions held? Does that remain static or does it vary? Please explain.
 3. How many sessions typically are completed before you have completed your treatment?
 - a. Do you find that most patient systems successfully complete their treatment before termination?
 4. What is the most common presenting issue that you face?

5. How many patients are on your caseload?

a. Please describe how you feel about your caseload?

Example: does your caseload size negatively impact your ability to provide quality services?

i. What do you think is the ideal caseload for someone working with this population? Is this different from the number you believe a clinician can handle with say an adult population? Please explain.

16. What barriers do you see facing the program in being able to successfully provide services to the zero to three population?

a. In your opinion, how has the agency addressed these barriers?

17. What barriers do you see facing families, in your catchment area, from being able to obtain your services? Please explain.

18. What barriers do you see hindering successful treatment of IMH issues?

a. How has the agency addressed these barriers? How have you addressed these barriers?

19. Do you receive on-going supervision in the infant/toddler program? What role does supervision play in the infant/toddler program?

20. How does your environmental context (i.e. your workplace, community) impact the agency's IMH services? Your IMH services? Please explain.

a. If so, how has the agency addressed these environmental issues?

b. How have you addressed these issues?

21. Are there similarities in your experiences between working with the clinical issues in adults and in working with children under the age of three? If so, give one specific example.
22. Are there differences in your experiences between working with the clinical issues in adults and in working with children under the age of three? If so, give one specific example.
23. In your opinion, what do you see as the most important successes of the program?
24. Do you have any further comments that you would like to make about the program? If so, please explain.
25. Stepping back from our conversation thus far, please explain what it was like to talk with someone from outside of the agency about these issues?
26. Would you have said anything different if I would have been from inside of the agency? Please explain.

Appendix D - Debriefing Handout

Dear Research Participant,

Thank you for participation in my research study. I appreciate your time and willingness to share your story with me. The number of identified young children with mental health issues continues to rise. There is a limited amount of research that has been carried out on how community mental health centers approach the treatment of the identified young children. Since the Community Mental Health Center of Crawford County has been on the frontier with the creation of the new program for infant mental health, I am greatly interested in further understanding how the program was created and how you experienced the creation and initial implementation of this new program. Your story provides important evidence suggesting that this type of unique program can be created and successfully implemented.

Your contribution to this study will aid in the development of a new understanding about creating and implementing community mental health programs that systemically address infant mental health concerns.

If you feel that it is necessary to further explore your experiences involving your participation with this program's creation and implementation; please seek out the most appropriate referral for you, from the list below.

- 1) Andrews & Associates, Inc. 1019 Poyntz Ave., Manhattan, KS 66502; 785-539-5455.
- 2) Kansas State University Family Center, 139 Campus Creek Complex, Manhattan, KS 66506; 785-532-6984.

3) CFCC & Associates, Inc. 2000 SW Gage Blvd, Topeka, KS 66604; 785-272-0778

I will be providing you a copy of the information, that I plan to use from your interview, for this research project. I would like to ask that you review the information so as to assure me that I have properly heard your experience. If you find a statement, that doesn't fit the message that you conveyed to me during the interview process, please inform me of the incorrect information and I will promptly make the needed correction. I will contact you primarily to providing the information to you in order to determine the most effective manner in which to get the information to you. During this conversation, I will also inquire as to the simplest way to get feedback from you.

Again, thank you for your participation!

Sincerely,

Corey D. Schliep, Doctoral Candidate

Kansas State University

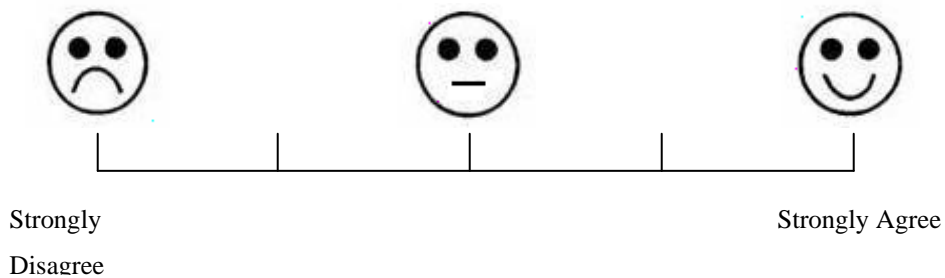
Interview Feedback Results

BRIEF SUMMARY

.....
.....]

*After reading the summary above, I believe it accurately represents the statements
I made during my interview.*

(Please place an “X” on the following scale representing your response)



Please use the space below to clarify or correct any of the information in the summary. If you would prefer to set a time for an additional interview, please note your request below.

Appendix F: Formal Agency Agreement

Memorandum of Agreement

This is an agreement made and entered into on January 1, 2007 between **Head Start Zero to Five**, a program of **SEK-CAP, Inc.** and **Discovery Center**, a program of **Community Mental Health Center of Crawford County**, a program of **Crawford County Health Department**.

Agency Address:

SEK-CAP, Inc.

Head Start Zero to Five

Cr. Co.

401 North Sinnet, PO Box 128

Girard, KS 66743

Agency Address:

Discovery Center

Community Mental Health Center of

212 E. 5th

Pittsburg, KS 66762

Federal Identification Number:

48-0725078

Federal Identification Number:

48-6042132

Child Care License Number:

46007-01

Statement of Vision:

Discovery Center, a program of CMHCCC and SEK-CAP Head Start Zero to Five seeks to provide comprehensive and integrated quality child care and family services to mutually shared populations. It is our mutual vision that integrating services will provide quality child care, enhance parent and child relationships, specifically families with children ages 0-5, support families in sound family functioning with the goal of self-sufficiency, and support families in meeting the needs of the whole person, including, health, mental health and nutrition. Mutually served clients will include families that present with high risk factors but are not limited to: Low income, poverty, mental illness, substance abuse, abuse/neglect history, high risk pregnancies, physical/mental/cognitive disabilities. Collaborative service design includes SEK-CAP Head Start Zero to Five and will provide staff and services meeting the definition for Early Head Start and Head Start Center based options. CMHCCC will provide a full array of comprehensive community based mental health services to treat mental illness and/or substance abuse that are impairing the parent/child bonding and attachment or parenting styles that lead to abuse and/or neglect of infants, toddlers, and preschoolers and their families, or places them at risk for out-of-home placement.

Proposed Changes to Existing Child Care License and Program Design:

1. Discovery Center/CMHCCC will retain the child care license #46007-01 for the entire facility as authorized in most recent KDHE license visit.
2. SEK-CAP Head Start Zero to Five will lease the space for Rooms #101, 102, and 103 for the sum of \$1.00 per month until May 31, 2009. At such time the rate of payment for lease and utilities will be renegotiated.
3. SEK-CAP Head Start Zero to Five shall be responsible for the employment and staffing for Rooms #101, #102, and #103.

4. CMHCCC/Discovery Center shall provide community based mental health service providers to deliver mental health services on site and in the community to mutually shared and identified clients between SEK-CAP Head Start Zero to Five and CMHCCC. CMHCCC will be responsible for the treatment component of the collaborative design and integrated Early Childhood Mental Health and SEK-CAP project. Services to be provided by CMHCCC include but are not limited to: Therapy, Psychosocial Treatment, Case Management, Medication Evaluation, Nursing (Allocated Health Department Staff), Parent Education, and Family Support. Regularly scheduled clinical supervision and consultation will be negotiated in order to facilitate open communication regarding the families the said agencies mutually serve.
5. CMHCCC/Discovery Center will be responsible for the maintenance and repair of the facility under KDHE license #46007-01. SEK-CAP Head Start Zero to Five will provide for the day-to-day custodial needs of the leased space in Rooms #101, 102, and 103.
6. CMHCCC/Discovery Center will provide existing and available equipment for use by SEK-CAP Head Start. SEK-CAP will assume responsibility for equipment that is broken or in need of repair.
7. CMHCCC/Discovery Center will provide the nutrition for all rooms under the license as well as the employment of the Dietary Manager. SEK-CAP Head Start will reimburse CMHCCC for ½ of the Dietary Manager salary equal to \$12,549.55 annually. Payment will be due quarterly beginning March 31, 2007 in the amount of \$3,137.38 and each quarter thereafter. CMHCCC will assume responsibility for benefits of the employee. CMHCCC/Discovery

Center will be responsible for administering the KSDE CACFP program and submitting reports necessary for the food and snack reimbursement.

8. SEK-CAP Head Start Zero to Five will be responsible for the transportation of children served in Rooms #101, 102, and 103. CMHCCC/Discovery Center will be responsible for the transportation of children served in the rooms remaining under the KDHE license.
9. SEK-CAP Head Start Zero to Five will be responsible for the advertisement or services and openings related to the collaborative project between CMHCCC/Discovery Center and SEK-CAP.
10. A mutually agreed upon process regarding concerns/complaints of parents will be reviewed by both agency Executives and/or their designees to determine the appropriate response and responsibility for response.
11. SEK-CAP Head Start Zero to Five and CMHCCC/Discovery Center shall meet all the regulations pertinent to KDHE and exceed them through implementation of the Performance Standards required by Head Start and Early Head Start services.
12. CMHCCC/Discovery Center will maintain records for each child under the licensed facility in compliance with the regulations of KDHE.
13. Liability Status—SEK-CAP Head Start Zero to Five shall provide services for Room #101, 102, and 103 described in this agreement and nothing herein shall be interpreted or construed as creating or establishing the relationship of the employer and employee between CMHCCC and SEK-CAP Head Start.

SEK-CAP Head Start agrees to maintain, at its sole cost and expense, the necessary licenses, employer identification numbers, certificates, professional affiliations, and to remain in full compliance with all

applicable laws, codes, and regulations including, but not limited to, those currently in existence or adopted hereafter from time to time. SEK-CAP Head Start shall bear sole responsibility for payment of compensation of its personnel. SEK-CAP Head Start shall pay and report, for all personnel assigned to perform any work under this Agreement, any and all federal and state income tax withholding, social security taxes, and unemployment insurance retirement benefits, or other welfare or pension benefits (if any) to which such personnel may be entitled. SEK-CAP Head Start agrees to defend, indemnify and hold harmless CMHCCC, CMHCCC officers, directors, employees, and agents, and the administrators of the Center's benefits plans from and against any claims, liabilities, or expenses relating to such compensation, tax, insurance or benefit matters.

SEK-CAP Head Start and CMHCCC, at its own cost, shall maintain business and professional liability insurance in an amount of not less than one million dollars (\$1,000,000) per occurrence for any liability claim arising from the operation of this agreement and two million dollars (\$2,000,000) aggregate. SEK-CAP Head Start and CMHCCC shall also maintain auto liability insurance of no less than one million dollars (\$1,000,000) per each accident. SEK-CAP Head Start and CMHCCC shall maintain Worker's Compensation Statutory Limits and Employer's Liability limits of not less than one hundred thousand dollars (\$100,000) each accident, one hundred thousand dollars (\$100,000) each disease, per employee and five hundred thousand dollars (\$500,000) each disease, policy limit. The parties shall provide to each other their respective proof of insurance within thirty (30) days of the execution of this Agreement, upon any renewal of this

Agreement, or at any other time upon request, will obtain and maintain professional liability insurance to include all liabilities incurred by SEK-CAP Head Start.

Hold Harmless

SEK-CAP agrees to assume responsibility for and to indemnify, protect, save, and hold harmless CMHCCC/Discovery Center from and against any and all liabilities, obligations, losses, damages, penalties, claims, actions, costs and expenses (including reasonable attorney fees), imposed on, incurred by or asserted against SEK-CAP Head Start, which in any way relates to or arises out of CMHCCC/Discovery Center's performance of the terms and conditions contained in this agreement, unless caused solely by CMHCCC/Discovery Center or its' agents.

CMHCCC/Discovery Center agrees to assume responsibility for and to indemnify, protect, save and hold harmless SEK-CAP Head Start from and against any and all liabilities, obligations, losses, damages, penalties, claims, actions, costs and expenses (including reasonable attorney fees), imposed on, incurred by or asserted against CMHCCC/Discovery Center which in any way relates to or arises out of CMHCCC/Discovery Center performance of the terms and conditions contained in this agreement, unless caused solely by SEK-CAP Head Start or its' agents.

The terms of this Agreement shall remain consistent with and in the spirit of compliance with the Memorandum of Agreement between KDHE and SRS that outlines the regulatory oversight for Discovery Center/CMHCCC.

This Agreement for service integration and collaboration is entered into on

December 4, 2006, between SEK-CAP, Inc. Head Start Zero to Five and Crawford County Health Department (CMHCCC and Discovery Center), licensed by the State of Kansas, named below and is in effect from 1/1/07 to 5/31/09.

Michael Ehling, Director of Children's Services Date

Richard H. Pfeiffer, Executive Administrator Date

SEK-CAP, Inc. by Linda Broyles, ECS Director Date

SEK-CAP Inc. by Steve Lohr, Executive Director Date

Appendix G: Contracted Research Agreement

CONTRACTED RESEARCH AGREEMENT

This agreement is entered into between Corey D. Schliep ["Contractor"] and Community Mental Health Center of Crawford County ["CMHCCC"], and the Southeast Kansas Community Action Program [SEK-CAP].

RECITALS:

- A. CMHCCC and SEK-CAP desires research services in accordance with the scope of work outlined within this agreement ["the Research"]; and
- B. The performance of the Research is consistent, compatible and beneficial to the role and mission of CMHCCC and SEK-CAP; and
- C. The Contractor has the capability to conduct the Research and desires to do so;

THEREFORE, the parties agree as follows:

Article 1. Scope of Work. Contractor will undertake the research program described in the research proposal attached and incorporated into this agreement as Exhibit 1, under the direction and supervision of Corey D. Schliep, principal investigator(s). Contractor may not designate any other person(s) as principal investigator(s), without the prior written consent of CMHCCC and the SEK-CAP.

Article 2. Contract Period. This agreement will become effective upon the signing of this agreement, and shall be completed on or before August, 2007, unless a time extension, continuation or renewal is mutually agreed upon in writing between the parties.

*******Addendum 3-17-08:** This agreement will remain in effect through Sept., 2008.

Article 3. Compensation. CMHCCC and SEK-CAP agrees to pay Contractor for the research services performed under this agreement in the amount not to exceed \$ 203.97 plus room tax in accordance with the budget itemized in Exhibit 2. Payments shall be made as follows:

All payments shall be made to Corey D. Schliep and mailed to:

Corey D. Schliep
2000 SW Gage Blvd
Topeka, KS 66604

Article 4. Reporting Requirements. Contractor will provide reports on the progress of the Research described in Exhibit 1 as follows:

A final report will be furnished at the completion of the contract period.

Article 5. Access to Records.

- (a) The Contractor will adequately account for and maintain reasonable records of their performance and allow access to these records by the directors of the CMHCCC and SEK-CAP. Access to these records will be provided within a reasonable amount of time upon receiving the request for access. This access will be for auditing purposes and in determining compliance with the terms of this contract.
- (b) The Contractor will submit a record of expenditures incurred for the performance and completion of this agreement. The CMHCCC and SEK-CAP may verify all expenditure receipts and disperse funds in an amount equal to the approved expenditures.
- (c) All records pertaining to this agreement must be retained by the Contractor for a period of three years from the completion date. If any litigation, claim or audit

pertaining to this agreement is started before the expiration of the three year period, the records must be retained until the litigation, claim or audit findings have been resolved.

- (d) The contractor will be granted access to records and information pertaining to this project under the supervision of the directors of the CMHCCC and SEK-CAP. All information shared for the purposes of this project are bound by strict confidentiality policies and the contractor agrees that no information pertaining to client records or staff information that is deemed confidential by the directors of the CMHCCC and/or SEK-CAP will be included into reports unless it is officially approved in writing by the directors CMHCCC and/or SEK-CAP. The information shared will only be used to further the research purposes outlined in exhibit #1.

Article 6. Publication and Confidentiality.

- (a) The parties each have the right to publish any and all information, conclusions or developments (except that which is designated as confidential by the CMHCCC or SEK-CAP in accordance with client confidentiality regulations) resulting from work conducted under this agreement. Publication by either of the parties shall give proper credit to the other party.
- (b) The parties will submit to each other any material released for publication prior to submission to the publisher for the purpose of comment, review, and advice by the

other with respect to the presence of patentable, confidential and/or proprietary subject matter within the material released for publication.

- (c) The parties agree to take all reasonable steps to have United States patent applications, or other appropriate protection of intellectual property, filed prior to the time the information, conclusions or developments are published or otherwise made available to the public.
- (d) Contractor agrees to keep confidential any proprietary information supplied to it by the CMHCCC and/or SEK-CAP during the course of Research performed by Contractor and designated as "confidential." Such information will not be included in any published material without prior written approval by CMHCCC and SEK-CAP.

Article 7. Equipment. Special equipment purchases under the terms of this agreement become the property of Contractor unless otherwise specified herein.

Article 8. Relationship of the Parties.

- (a) It is mutually agreed that Contractor is an independent contractor and not an employee of CMHCCC and/or SEK-CAP for purposes of this agreement. No benefits provided by CMHCCC and/or SEK-CAP to its employees, including

unemployment and workers' compensation insurance, will be provided to the Contractor or its employees.

- (b) This agreement will not constitute, create or in any way be interpreted as a joint venture, partnership or formal business organization of any kind.

Article 9. Non-discrimination. Contractor agrees that no part of this agreement will be performed in a manner which illegally discriminates against any person on the basis of race, color, religion, creed, political ideas, sex, age, marital status, physical or mental handicap, or national origin.

Article 10. Indemnification.

- (a) Contractor agrees that it is financially responsible and assumes liability for any audit exception resulting in a financial loss to CMHCCC and/or SEK-CAP due to the negligence, intentional acts, or failure of the Contractor, its employees, agents or representatives, to comply with the terms of this agreement.
- (b) Each party agrees to be responsible and assume liability for its own wrongful or negligent acts or omissions, or those of its officers, agents or employees, to the full extent required by law, and agrees to indemnify and hold the other party harmless from any such liability.

- (c) Each party agrees to maintain reasonable coverage for such liabilities either through commercial insurance or a reasonable self-insurance mechanism, and the nature of such insurance coverage or self-insurance mechanism will be reasonably provided to the other party upon request. This insurance for the contractor should be a minimum of professional liability insurance. The CMHCCC and SEK-CAP are responsible for their own insurance coverage based on the standards for their given agency types.

Article 11. Dispute Resolution.

- (a) Any dispute regarding or arising under this agreement will be subject to and resolved in accordance with the laws of the State of Kansas.
- (b) Any dispute regarding or arising under this agreement should be first discussed within the contracting officials (the contractor, director of CMHCCC, and the director of SEK-CAP) first in an attempt to resolve the dispute. If the dispute is not resolved then the parties agree to official mediation to be conducted by Kansas State University or their designee.
- (c) If the process is not resolved through official mediation, it is agreed by the parties that venue for any legal proceeding, including an alternative dispute resolution proceeding, to enforce or interpret this agreement will be conducted in Crawford County, Kansas.

Article 13. Assignment, Transfer and Subcontracting. This agreement, or any interest in this agreement, may not be assigned or transferred, unless both parties agree in writing. No services required under this agreement may be performed under subcontract unless both parties agree in writing.

Article 14. Patents and Inventions.

- (a) The Contractor will promptly notify CMHCCC and SEK-CAP in writing of any potentially patentable inventions or discoveries arising out of Research performed under this agreement. Ownership in any invention or discovery conceived and reduced to practice solely by one party in the performance of this agreement will reside in that one party, and any patent rights in or patent issued thereon will reside in that one party.
- (b) Ownership in any invention or discovery conceived and reduced to practice jointly by personnel of both parties and any patent rights in or patent issued thereon will belong to both parties jointly. Decisions on when, where and whether to file patent applications, for jointly owned inventions, will be made by CMHCCC and SEK-CAP after consulting with Contractor. CMHCCC and SEK-CAP will prepare, file and prosecute such U.S. and foreign patent application in the name of both parties. All

costs for the preparation, filing and prosecution of patent applications for joint inventions will be shared equally by the parties.

- (c) Contractor hereby warrants that it has the right and will require the personnel involved in this Research to assign their interests in any proprietary rights developed under this agreement to Contractor or to the parties jointly if a jointly owned invention.
- (d) Although Contractor will have the sole responsibility for filing patent applications for its solely owned inventions conceived and reduced to practice in the performance of this agreement, CMHCCC and SEK-CAP will have the right, prior to filing of any such application, to review and approve the scope and content of such patent application.
- (e) Contractor agrees to assist CMHCCC and SEK-CAP in assembling inventorship information and data for filing patent applications and to provide all necessary assistance to MSU in the filing and prosecution of patents. Contractor agrees to assist CMHCCC and SEK-CAP in the preparation, filing and prosecution of patents even if such procedure may take place after the termination date of this agreement.

Article 15. Use of Names. Neither party will include the name of the other party or any of its employees in any advertising, sales promotion or other publicity matter without prior written approval.

Article 16. Modification. This agreement contains the entire agreement between the parties, and no statements, promises or inducements made by either party, or agents of either party, that are not contained in this agreement are valid or binding. This Agreement may not be enlarged, modified, or altered except by written amendment by the parties.

Article 17. Termination.

- (a) This agreement may be terminated at any time upon the written mutual consent of the parties.

- (b) Either party may terminate this agreement for failure of the other party to inform any of the services, duties or conditions contained in this agreement after giving the other party written notice of the stated failure. If the Contractor does not correct the failure within the ten (10) day period, or any longer period agreed to in writing by the parties, the termination is effective at the end of the specified period.

(c) The above remedies are in addition to any other remedies provided by law or the terms of the agreement.

This agreement is executed by the parties on the dates set forth below by their duly authorized representatives.

CMHCCC and SEK-CAP

By: _____ (CMHCCC)

Title: _____

Date: _____

By: _____ (SEK-CAP)

Title: _____

Date: _____

CONTRACTOR

By: _____

Title: _____

Date: _____

Project Budget

Per this agreement, CMHCCC and/or SEK-CAP have agreed to pay for the lodging of this researcher while the interviews are taking place in Crawford County. This researcher will be staying no more than three nights in Pittsburg, Kansas at the Comfort Inn. The nightly corporate rate for these accommodations runs \$67.99 per night plus tax. The CMHCCC and/or SEK-CAP agree then to pay the entire cost of lodging, not to exceed \$203.97 plus tax.

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