The Connecticut Association for Infant Mental Health

2009 Infant/Early Childhood Mental Health Clinician Survey Project Final Report

The Connecticut Association for Infant Mental Health gratefully acknowledges the William Casper Graustein Memorial Fund for its financial support of this project and Samantha Goodrich, University of Connecticut, for her work in conducting the survey, preparing and presenting the report of the project.

CONNECTICUT ASSOCIATION FOR INFANT MENTAL HEALTH

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Executive Summary

Infant Mental Health (IMH) services have been defined as those promoting the optimal growth of social-emotional, behavioral, and cognitive development of very young children in the context of the unfolding relationship between parents and infants, toddlers, and preschoolers. Good mental health consists of nurturing, stable relationships between the child and caregiver as well as healthy emotional expression (Holmberg, 2009). In recent years, there has been a focus on encouraging the healthy development of infants and toddlers and on providing services and programs for at-risk children, who may not have access to an enriching environment that will encourage their intellectual and social-emotional growth (Ramey & Ramey, 1998). When young children are mentally healthy, it prepares them to thrive in settings outside the home, such as school, and to have successful interactions with peers as they continue to grow.

A number of consistent findings in research have made the importance of infant mental health in general and programs for those who are at-risk of not successfully developing clear. First, considering the child in the context of his or her environment is essential to infant mental health. A particularly important element of this environment is the relationship between the child and his or her caregiver. Early relationships are an important source of support for young children and have been shown to have a strong influence of a child's development of social (Shonkoff & Phillips, 2000). Finally, early experiences are not only important for concurrent development but also have a large effect on later life (Ramey & Ramey, 1998). As such, early intervention services may address the family as a unit, the primary caregiver and the child's relationship with him or her, or the child as an individual (Ramey & Ramey, 1998). By address all three levels, Infant Mental Health services focus on the context of a child's life to ensure that he or she is offered positive opportunities and experiences within the an engaging and supportive environment.

Another important element of providing strong services in this area is reflective practice. Reflective practice means "having the ability to examine one's own thoughts and feelings related to professional and personal responses within the infant and family field" (Michigan Association for Infant Mental Health as cited by Mendez-Begnal, 2009). It allows professionals in the field to be present in their work and continually examine their own behavior and work so that they can be a successful provider for young children.

Today there are Associations of Infant Mental Health throughout the country, such as in Michigan, Wisconsin, and Connecticut. These groups work to strengthen practice in the IMH field and advocate for families who need services. The Michigan Association for Infant Mental Health has even developed *The Competency Guidelines*, which provide standards for professionals in the field so that they can measure their abilities against these competencies. The goal is to strengthen the field of professionals providing these important services and make the field a more cohesive unit. In Connecticut, it is clear that Infant Mental Work is being carried out; however, it is not clear who is providing what types of services or who identifies themselves as doing IMH work.

As an initial step to strengthening Connecticut's IMH services, a survey was created and administered over the phone to those providing mental health services to children under the age of five. The goal of the survey was to not only determine who identifies themselves as doing this work, but also what services are actually being provided. Questions asked on the survey

concerned general information about the program, funding, the population served, services provided, assessments used, areas of specialization, and professional requirements.

A total of 98 individuals and institutions were contacted to participate in the survey. This list was a combination of child guidance clinics, Value Options provider list, board members, and other known individuals in the field. In the end, the sample consisted of 34 individuals. A few individuals worked in more than one location, resulting in 38 locations in the sample.

Among those surveyed, thirty people (79%) were part of a group practice or program, and eight people (21%) reported being in an individual practice. When asked if their services were considered prevention, early intervention, or treatment, the most common response was that the services provided fell into all three categories (13 people, 33%). Looking at the setting in which the individual or program was operating, the most common settings were Child Guidance Clinic (CGC, 9 people), Private Practice (10 people), and Home-Based (11 people).

Participants were asked how their program or practice was funded. Twenty-seven people reported their practice or program is funded by fee-for-service, and the same number reported accepting insurance. An additional 13 programs and practices are grant funded, and 24 are state funded (typically by DCF). Notably, 12 individuals reported that their program or services are provided at no cost to families, or they have a sliding scale for payment based on one's income, ensuring that everyone is eligible for services.

When asked what ages (under the age of 5) the program or practice is able to provide services for, an overwhelming majority (28 out of 38) reported being able to serve children in the entire birth to age 5 range. The programs, clinics, and practices included in this sample are located in 28 different cities and towns throughout the state. Only one location was included from any given town, but more than one location was included from the three major cities in Connecticut - New Haven, Hartford, and Bridgeport. Twenty participants also reported that they would serve people from any town or city in Connecticut.

Among the services provided, working on parent-child relations and conducting assessments are the most common services provided with 35 and 36 of the 38 participants respectively reporting that they provide these services. Looking at assessment more in-depth, social emotional development is the most commonly assessed area (92%), but relationship, attachment, newborn, and developmental disabilities assessment were all fairly common with at least 50% of the sample reporting that they provide assessment in those areas. The standardized measures that are most commonly used in assessments are the Child Behavior Checklist, Ages and Stages Questionnaire, the Bayley Scale of Infant Development, the Mullen Scale of Early Learning, and the Parenting Stress Index.

Survey respondents were also asked if they provide or receive reflective supervision. Ten participants receive reflective supervision, and twenty-two provide reflective supervision for others. Finally, the questions on size and structure of the programs turned out to be difficult to quantify because the answers were so variable. A master's degree is needed for a majority of people who work directly with the families, but for a few positions a bachelors degree or significant life experience is sufficient. Only three individuals reported that their program had a waitlist, and many cited the fact that they were an enhance care clinic as the reason for not having a waitlist. Finally, most programs did not have any eligibility requirements unless there was a sole purpose of their program, such as parents with substance abuse issues or children with clear developmental disabilities.

Overall, the data collected from this survey shows that there is a wide variety of programs and services being provided to children under the age of five to address their mental

health needs. The locations of the programs and clinics suggest that there are services provided throughout the state, particularly in the major cities. The greatest variability was shown in the structure of the program. There were small individual programs and programs that were well-established and had many sites across Connecticut. There were clinics that were solely out-patient clinics and clinics that were part of a larger site that offered many additional programs. Some programs offered home visits, some were community-based designed to connect parents with necessary resources, and some were outpatient clinics. There is not one type of setting or program that provides IMH services, yet it is also clear that there are some very strong and useful services addressing infant mental health needs in Connecticut.

There are some limitations to this study. The sample size is the biggest limitation with only 34 of 98 people responding (a 35% response rate). A number of reasons may have resulted in the small sample size, including unfamiliarity with CT-AIMH and not knowing a specific individual to contact at some of the clinics. Another limitation was the inconsistent structure of locations. Having such variability makes it difficult to make comparisons across different programs and sites; however, an alternative is hard to conceive while still being timely. In situations where numerous programs are housed within one clinic or site, it would take a director or supervisor too long to answer the survey about each program.

This survey provides a strong starting point in the efforts to address the availability of IMH services in Connecticut. More data should be collected about what exact services are provided and which services are based on research and practice. Clearer definitions should also be established. Hopefully in the future a network of providers offering infant mental health services will be created, which will assist in referrals and create a collaborative community of mental health providers.

Introduction

Infant Mental Health (IMH) services have been defined as those promoting the optimal growth of social-emotional, behavioral, and cognitive development of very young children in the context of the unfolding relationship between parents and infants, toddlers, and preschoolers. Good mental health consists of nurturing, stable relationships between the child and caregiver as well as healthy emotional expression (Holmberg, 2009). In recent years, there has been a focus on encouraging the healthy development of infants and toddlers and on providing services and programs for at-risk children, who may not have access to an enriching environment that will encourage their intellectual and social-emotional growth (Ramey & Ramey, 1998). When young children are mentally healthy, it prepares them to thrive in settings outside the home, such as school, and to have successful interactions with peers as they continue to grow.

A number of consistent findings in research have made the importance of infant mental health in general and programs for those who are at-risk of not successfully developing clear. First, considering the child in the context of his or her environment is essential to infant mental health. A particularly important element of this environment is the relationship between the child and his or her caregiver. Early relationships are an important source of support for young children and have been shown to have a strong influence of a child's development of social (Shonkoff & Phillips, 2000). Finally, early experiences are not only important for concurrent development but also have a large effect on later life (Ramey & Ramey, 1998). As such, early intervention services may address the family as a unit, the primary caregiver and the child's relationship with him or her, or the child as an individual (Ramey & Ramey, 1998). By address all three levels, Infant Mental Health services focus on the context of a child's life to ensure that he or she is offered positive opportunities and experiences within the an engaging and supportive environment.

Another important element of providing strong services in this area is reflective practice. Reflective practice means "having the ability to examine one's own thoughts and feelings related to professional and personal responses within the infant and family field" (Michigan Association for Infant Mental Health as cited by Mendez-Begnal, 2009). It allows professionals in the field to be present in their work and continually examine their own behavior and work so that they can be a successful provider for young children.

Today there are Associations of Infant Mental Health throughout the country, such as in Michigan, Wisconsin, and Connecticut. These groups work to strengthen practice in the IMH field and advocate for families who need services. The Michigan Association for Infant Mental Health has even developed *The Competency Guidelines*, which provide standards for professionals in the field so that they can measure their abilities against these competencies. The goal is to strengthen the field of professionals providing these important services and make the field a more cohesive unit. In Connecticut, it is clear that Infant Mental Work is being carried out; however, it is not clear who is providing what types of services or who identifies themselves as doing IMH work.

Present Study

As an initial step to strengthening Connecticut's IMH services, a survey was conducted to collect data on those who are providing IMH services. The goal of the survey was to not only determine who identifies themselves as doing this work, but also services are actually being provided.

Methods

This study consisted of creating a survey that addressed the types of services provided for children under the age of five and the capacity of programs, clinics, and practices in Connecticut. From there, the survey was piloted and necessary revisions were made after each round of piloting. Once piloting was complete, individuals throughout the state of Connecticut were contacted and asked to participate in the survey. They were informed that they would not specifically be identified in any way and only aggregate data would be presented.

Survey

Initially, a survey was created by members of AIMH based on questions of interest. The survey was designed to be completed over the phone and take no longer than 30 minutes. We felt having participants fill out the survey on their own and return it to us would not be as effective because there was a chance that we would not receive the answers we were looking for or questions may be interpreted incorrectly. An effort was also made to keep the survey a short as possible so that participating in our study would not be too time-consuming or tedious.

Questions asked on the survey concerned general information about the program, funding, the population served, services provided, assessments used, areas of specialization, and professional requirements. The last question on the survey asked if the individual knew of any other providers that we may have missed or that we should make sure to contact. This provided another outlet for finding people providing IMH services in Connecticut.

The survey was then piloted on 7 people who we were confident were providing IMH services and could provide useful feedback**.** Piloting ensured that the wording of the survey questions was asking for the information we had intended as well as ensured that all of the questions were in fact applicable to their work. Some changes were made to the survey were as a result of the piloting, and once we felt no other changes were necessary, a final version of the survey was completed. See Appendix A for the actual questions included in the Service Provider Survey.

Sample

A list of service providers in the state of Connecticut was comprised from a number of different sources over the course of the Summer and Fall of 2009. Value Options provided their list of providers who accepted Husky Insurance and identified themselves as providing services to those under the age of 5. In addition, a list of child guidance clinics in Connecticut that is publically provided by the 2-1-1 info line gave us a list of 65 child guidance clinics. Board members of the CT-AIMH were also included as well as any other clinicians or service providers that board members were aware of that were not already included in our list. Those who were in private practice as well as those part of a larger clinic or program were contacted. In the event that a clinic or service provider offered numerous programs and services a person who could speak to all of those services was contacted. Typically, this person was someone in a supervisory or director position.

This process resulted in contacting 98 individual clinicians and providers. Of the 98 contacted, 34 people responded to our request and completed the survey. Some individuals were in positions in more than one location, and in these cases they completed the survey for all positions. As a result, the sample for the results provided below consists of 38 locations.

Procedure

Contact was made by first sending an email that introduced our survey and the goal of our inquiry to those for whom we had email information. For those whom we did not have an email address, Samantha contacted the individual or site by phone, and a she left a message when no one could be reached. In addition, those who did not respond to the initial email were also contacted with a phone call. A script was designed for the initiation of the phone conversations. Often there was not a specific individual we knew to contact, and in those cases an individual who could speak to what services were provided for children under the age of five was requested.

If Samantha's initial contact, whether by email or phone, was responded to, a time was set up for her to contact the individual at their convenience when they would have 20-30 minutes to talk. On that day, she called the individual and the survey was completed. After the survey was completed, a follow-up email was sent to thank them for their time and provided Samantha's contact information in case any other questions arose. Survey completion began in June of 2009 and continued until December of 2009.

Connecticut Systems and Important Terms

Before discussing the results of the survey, this section will outline some of the major systems in place in Connecticut as well as some important terms that arose in the process of completing the surveys. This discussion is important because these terms are part of a common language used in the mental health field in Connecticut as was demonstrated in the process of completing these surveys. They help address some commonalities across service providers and describe structures they interact with on a regular basis.

Common Connecticut providers. There were a number of particularly common providers in Connecticut that have numerous sites all over the state. They were a common thread for many of the different clinics surveyed, yet they are each separate entities that do not only have sites in clinics. The most common providers include:

- **Birth – 3 :** A state agency that assists and strengthens the family's ability to address the developmental needs and delays of very young children.
- **Early Childhood Consultation Partnership (ECCP):** A consultation program designed to address the social and emotional needs for children age birth to five, particularly in the child's early care or educational setting.
- **Nurturing Families:** A free and voluntary program for first-time parents that provides home visits, parenting group, and nurturing connections. There are 33 sites throughout the state.
- **Family Resource Centers:** Centers in public schools throughout CT that provide access, within a community, to a broad continuum of early childhood and family support services which foster the optimal development of children and families. There are 62 schools with Family Resource Centers.
- **Family Based Recovery:** FBR is an free, intensive, and comprehensive in-home program for families referred by DCF because they have co-occurring caregiver substance abuse and a child age two or younger who is at risk of removal or poor developmental outcomes.
- **Child Guidance Clinics:** Community-based outpatient clinics that provide behavioral health services for children ages 0-18 and their families, regardless of their ability to pay. Each clinic is tailored to the needs of the particular community.

Enhanced care clinics. A number of clinics that participated in the survey noted that they were now considered Enhanced Care Clinics. The largest ramification of this label seemed to be that the clinics now had to see any patient within two weeks of them calling the clinic and even sooner for urgent care. According to the Connecticut Behavioral Health Partnership Website the goal of this credential is to improve the timeliness within which patients are seen as well as improve the quality of care. They state:

> Enhanced Care Clinics (ECC's) are specially designated Connecticut based mental health and substance abuse clinics that serve adults and/or children. They provide routine outpatient services such as individual therapy, group therapy, family therapy, medication management and other special services for CT BHP members (http://www.ctbhp.com/members/enhanced_care_clinics.htm).

See http://www.ctbhp.com/members/enhanced_care_clinics.htm for a complete list of Enhanced Care Clinics.

Best practices model. As part of the survey, respondents were asked if the program or clinic was based on any particular models. In the case of ECCP, the model they have developed is now actually considered a best-practices model that is evidence-based. This recognition is increasingly important in the field as a whole and hopefully more models will be recognized for implementing best practices as they prove to be evidence-based and effective.

Results

The results are presented based on the order they were asked in the survey. Those surveyed were mostly directors or supervisors. Other positions held included clinician, consultant, and program manager. In addition, all but one respondent had at least a master's degree. Fifteen of the 34 respondents had their MSW and/or were LCSWs. An additional 10 people had their master's degree in a related field, such as counseling or early childhood, and 9 individuals had received their PhD in a variety of fields, including clinical psychology, education, and child development.

General Information

Among those surveyed, thirty people (79%) were part of a group practice or program, and eight people (21%) reported being in an individual practice. Among those eight people in individual practice, two of the individuals also held a position in a group setting and seven of the eight were clinicians in private practice. Respondents were then asked if their services were considered prevention, early intervention, or treatment services. Six respondents reported only one category – 1 prevention, 1 early intervention, and 5 treatment. The most common response was that the services provided fell into all three categories (13 people, 33%). The remaining 16 people chose only two of the three categories, and all combinations were represented in the sample.

Setting

Figure 1 shows responses to the question asking in which setting the program was operating. The most common settings were Child Guidance Clinic (CGC), Private Practice, and Home-Based. Among those most common settings, 5 of the 9 CGCs and 5 of the 9 home-based

programs responded being solely in that setting. For those in private practice, 9 of the 10 people reported being solely private practice, and one location offers both private practice and a Child Guidance Clinic. All four of the groups who reported being university affiliated only identified as university affiliated. Only one program reported being solely community based, and the other two were also home-based or provided a rehabilitation center in addition to being community-based. One individual reported that they operated in the community, center, and home, but no other respondents identified their programs as being in more than two settings. See Figure 2 for the number of individuals who reported operating in only one setting.

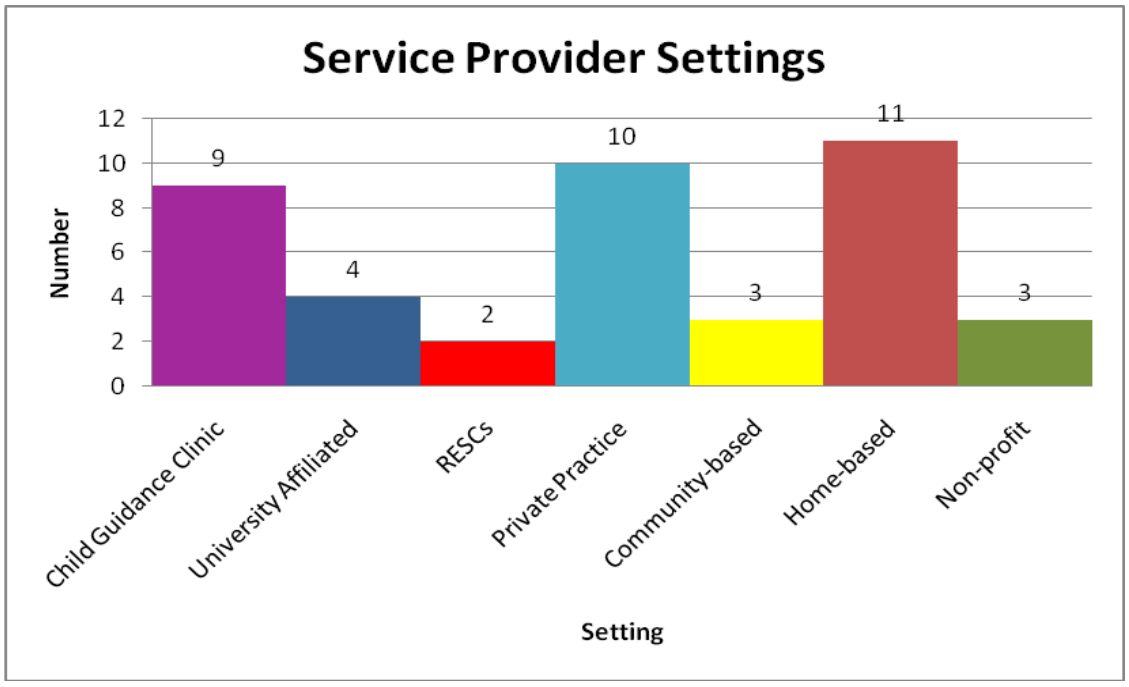

***Figure 1*. The settings in which the programs operate. Note that some chose more than one option.**

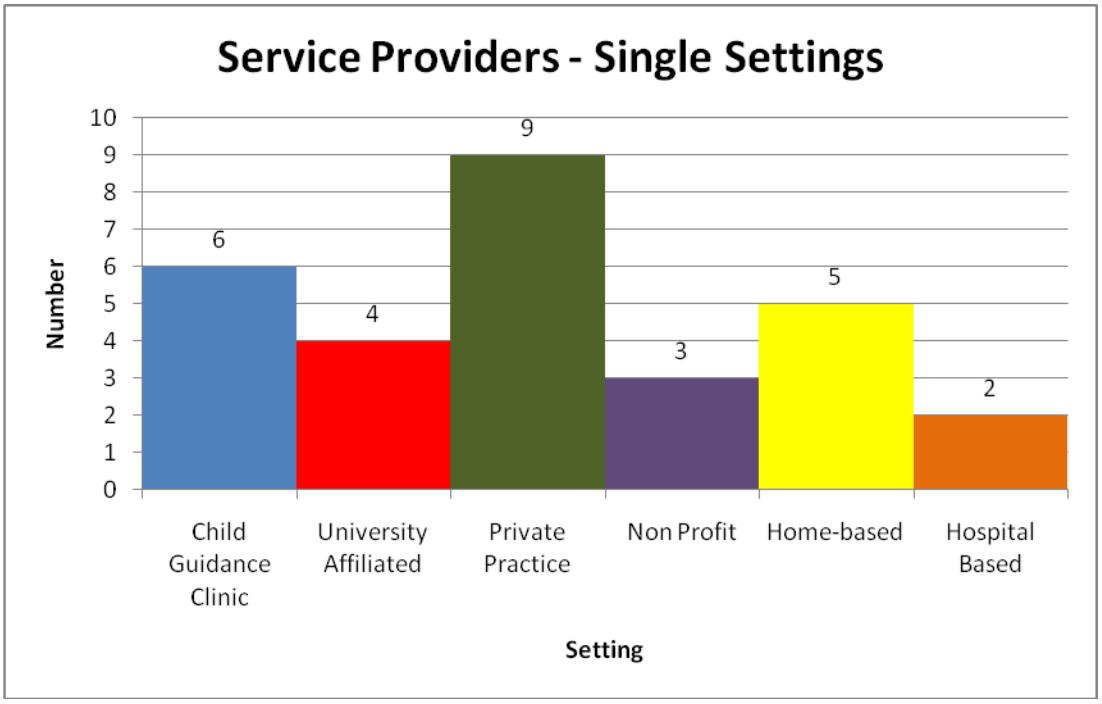

***Figure 2*. The number of respondents who chose only one setting in which their program or practice operates.**

Funding

Participants were asked how their program or practice was funded. The categories included were fee-for-service, insurance, grant funded, state funded, and other. Respondents could choose more than one option, so the numbers reported add up to a number greater than the number of participants. Twenty-seven people reported their practice or program is funded by fee-for-service, and the same number reported accepting insurance. Of the 27 programs or practices that accept insurance, 24 of them particularly accept husky insurance as well as private insurance. An additional 13 programs and practices are grant funded, and 24 are state funded (typically by DCF). Other funding sources reported included federal funding, university funding, and personal contributions. Notably, 12 individuals reported that their program or services are provided at no cost to families, or they have a sliding scale for payment based on one's income, ensuring that everyone is eligible for services. Overall, 28 individuals selected more than one type of funding source.

Population Served

When asked what ages (under the age of 5) the program or practice is able to provide services for, an overwhelming majority (28 out of 38) reported being able to serve children in the entire birth to age 5 range. Among the ten who do not serve all young children, only 3 reported only being able to serve children above the age of 3. The remaining seven programs and practices only served children under the age of 3. In addition, twenty-one sites serve pregnant women, and they all follow-up with the mother after birth.

Location

The programs, clinics, and practices included in this sample are located in 28 different cities and towns throughout the state. Figure 3 shows the towns included in the sample broken down by areas of the state. There are roughly an equal amount of cities included from the north and south of the state, with a few less in the western region. More than one location was included from the three major cities in Connecticut - New Haven, Hartford, and Bridgeport. Hartford surpassed any other city or town, with eight different sites being included in the sample. Eleven individuals also reported that their program or clinic served a specific encatchment area, and an additional seven cited serving a general area of the state (e.g. Southern CT, Northwest CT). The remaining 20 participants reported that they would serve people from any town or city.

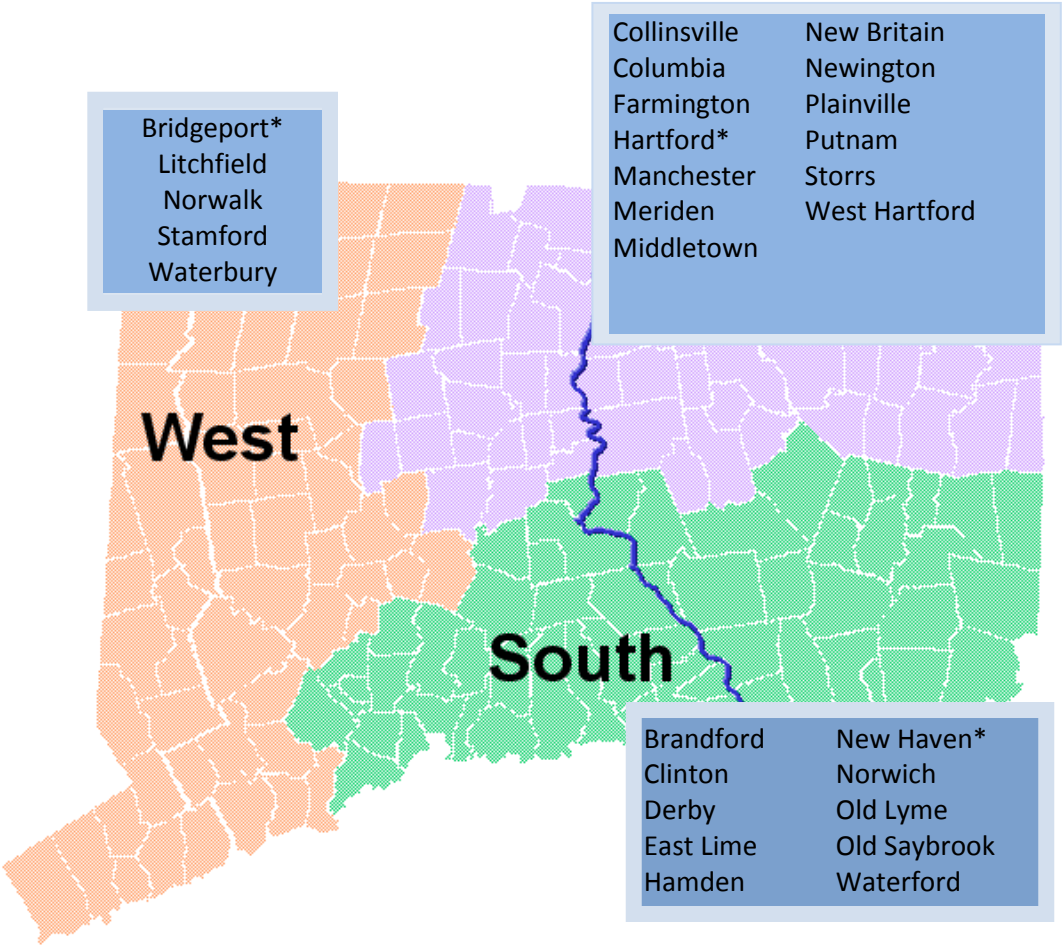

Figure 3. **Shows the towns included in the sample broken down by region.**

*** more than one location within that town or city are included in the sample**

Services Provided

A list of possible services was provided to respondents, and they were asked to report if their program, clinic, or practice provided that service. An additional "other" option was provided at the end to allow them the opportunity to included any other important or common services they provide. Table 1 shows the number of individuals who reported yes to providing each service as well as the percent of the sample that responded yes. Assessment and working on parent-child relations are the most common services provided. The high number of yeses reported to each of the services provided in our list also suggests that these are all common services provided when doing infant mental health work. Other common services cited include: home visits (5), parent guidance/education/training (5), oversee supervised visits (2), staff development/training (2), connecting families/parents with other resources/services (5). As one can see, no more than five people commonly reported a service not included on our list.

Table 1

Number and Percent of Programs Providing Services

Service	Number Yes	Percent Yes
Assessment	**36/38**	**95**
Play Therapy	29/36	81
Parent-Child Relations	**35/37**	**95**
Parent-Child Psychotherapy	29/37	78
Parent Groups	21/33	64
Case Management	26/33	79
Consultation to Early Care Settings	31/38	82

Note. Percents are the Valid Percent, i.e. percent out of those who answered question.

Assessment

The next set of questions addressed the type of assessments typically completed for clients as well as what specific standardized tools are used as part of the assessments. As Table 2 shows, the most commonly assessed area is social emotional development with 92% of the sample reporting that their program, clinic, or practice assessed this area of development. This response should be expected in infant mental health services as a large focus should be social-emotional development. All of the categories, with the exception of relationship assessment for custody determination, had a response rate of at least 50%. Similar to other questions, there was an opportunity to identify other areas of assessment that were commonly addressed in their program or practice. Although there were no other areas that were listed very often, other categories of assessment included psychosocial risk factors, child abuse potential, classroom environment, autism specific, medical history, cognitive, language, motor, trauma, and comprehensive family needs.

Table 2.

Number and Percent of Respondents Conducting Assessment in Various Areas

Area of Assessment	#	%
SE Dev Assessment	35	92
Relationship Assessment	27	71
Attachment Assessment	22	58
RA for Custody Determination	5	13.2
Newborn Assessment	19	50
Developmental Disabilities	24	63

Respondents were then further asked whether or not they used specific common, standardized tools. Again, they were asked to report any others that they used that were not part of the list. Table 3 depicts the number of participants who report using the ten different tools included in the list. The WPPSI is the least commonly used, but all the others are used by at least 30% of the sample. There was a wide range of other tools listed that were not included in this list. The original list as well as tools reported by two or more respondents are listed in Table 4. The table also shows which area the tool addresses. Finally, twenty-nine individuals reported that their program, clinic, or practice also used observation as an assessment tool.

Table 3.

Number and Percent of Programs Using Specific Standardized Tools

Tool	#	%
Child Behavior Checklist (CBCL)	16	46
Behavior Assessment System for Children (BASC)	10	29
Vineland Adoptive Behavior Scale	14	40
Bayley Scale of Infant Development	15	43
Wechsler Preschool and Primary Scale of Intelligence (WPPSI)	8	23
Mullen Scales of Early Learning	15	44
Parenting Stress Index (PSI)	17	50
Ages and Stages Questionnaire (ASQ)	21	62
Ages and Stages Questionnaire – Social Emotional (ASQ-SE)	18	51
Infant Toddler Social Emotional Assessment (ITSEA)	13	38

Table 4.

Areas Addressed by the Most Commonly Reported Assessment Tools

Assessment Tool	BHVR	DEVL	DD	ENV	SE	REL	PAR	LANG	MOT	INT
Child Behavior Checklist (CBCL)	✓				✓					
Behavioral Assessment System for Children (BASC)	✓									
Vineland Adoptive Behavior Scale	✓		✓							
Bayley Scale of Infant Development		✓								
Wechsler Preschool & Primary Scale of Intelligence (WPPSI)										✓

Assessment Tool	BHVR	DEVL	DD	ENV	SE	REL	PAR	LANG	MOT	INT
Mullen Scales of Early Learning								✓	✓	
Parent Stress Index						✓	✓			
Ages and Stages Questionnaire (ASQ)		✓								
Ages & Stages – Social Emotional (ASQ-SE)		✓			✓					
Infant Toddler Social Emotional Assessment (ITSEA)										
Sensory Profile			✓							
Parental Bonding Instrument (PBI)						✓	✓			
Autism Diagnostic Observation Schedule			✓							
KEMPE Assessment						✓				
Center for Epidemiologic Study – Dep. Scale					✓					
The HOME Assessment				✓						
Infant-Toddler Environment Rating Scale (ITERS)				✓						
Early Childhood Environment Rating Scale (ECERS)				✓						
Caregiver-Teacher Report Form (CTRF)	✓	✓			✓					
Infant-toddler Development Assessment (IDA)	✓	✓				✓				
Edinburgh Postnatal Depression Scale					✓		✓			
Battelle Developmental Inventory		✓			✓					
Devereaux Early Childhood Assessment (DECA)	✓					✓				
Hawaii Early Learning Profile Checklist (HELP)		✓								
Developmental Assessment Of Young Children (DAYC)			✓							
Modified Checklist for Autism in Toddlers (MCHAT)			✓							
Preschool Learning Scale (PLS)								✓		
Peabody Picture Vocab Test (PPVT)								✓		
Brief Infant Toddler Social Emotional Assessment (BITSEA)					✓					

Key:

BHVR	**Behavioral**
DEVL	**Developmental**
DD	**Developmental Delays/Disabilities**
ENV	**Physical Environment**
SE	**Social Emotional**
REL	**Relationship**
PAR	**Parent**
LANG	**Language**
MOT	**Motor**
INT	**Intellegence**

Area of Specialization

Respondents were asked if their program, clinic, or practice was particularly equipped to address a certain area of need, i.e. did they specialize in any area. A list was provided and other areas could be added at the end. Sensory integration, behavioral and emotional issues, trauma, developmental disabilities, sleeping disorders, and feeding disorders were included in the provided list. Over 50% of participants responded yes to behavioral and emotional issues, trauma, and developmental disabilities. Between 40-50% responded yes to the other three categories. The most common area of specialization was behavioral and emotional issues (97%). Other areas of specialization identified were attachment, parenting/relationship skills and issues, maternal depression, and the classroom environment.

Reflective Supervision

One particular question asked whether the respondent either received or offered reflective supervision as part of their position. If it was unclear what was meant by reflective supervision, a definition was provided, and respondents who answered No were asked if they did anything similar. Most people were in fact familiar with the concept of reflective supervision. Ten participants receive reflective supervision, and twenty-two provide reflective supervision for others. The high number of people providing reflective supervision is likely due to the fact that twenty-four people are in a supervisory position of some sort and are likely providing guidance to other clinicians. A common response was that people felt that they wished they received more of it or if they did not receive or offer any at all, they wished that was incorporated in their work.

Size and Structure

The questions on size and structure of the programs turned out to be difficult to quantify because the answers were so variable. Part of this result is due to the fact that in some cases particular sites house a number of different programs, each with its own size and structure. The credentials necessary for those who worked directly with the families varied based on the position. Typically a master's degree is needed, but for a few positions a bachelors degree or significant life experience is only required. The BA positions are not clinical positions. The size of the program was the least reliable question on the survey, as most did not have a good idea of how many people they served (again due in part to the fact that they were often accounting for a number of different programs). Only three individuals reported that their program had a waitlist, and many cited the fact that they were an enhance care clinic as the reason for not having a waitlist. Finally, most programs did not have any eligibility requirements unless there was a sole purpose of their program, such as parents with substance abuse issues or children with clear developmental disabilities.

Conclusions and Limitations

Overall, the data collected from this survey shows that there is a wide variety of programs and services being provided to children under the age of five to address their mental health needs. The locations of the programs and clinics suggest that there are services provided throughout the state, particularly in the major cities. The greatest variability was shown in the structure of the program. There were small individual programs and programs that were well-established and had many sites across Connecticut. There were clinics that were solely out-patient clinics and clinics that were part of a larger site that offered many additional programs.

Some programs offered home visits, some were community-based designed to connect parents with necessary resources, and some were outpatient clinics. There is not one type of setting or program that provides IMH services, yet it is also clear that there are some very strong and useful services addressing infant mental health needs in Connecticut.

Looking at assessment particularly, assessment using standardized tools is very common, yet which tools are necessary and most useful differed across programs. This finding is reflective of the field as a whole as there are a number of different tools to address each area of development and well-being, and typically it is not clear if one is better than another. Social emotional assessment and services seemed to be a focus of many of the programs included, which should be expected in infant mental health services. In the future it would be interesting to find out if those who report doing assessments in particular areas use assessment tools that best evaluate and address those areas.

The biggest limitation of this study is the sample size. Although a large sample was contacted and invited to participate in the study, only 34 individuals participated. There are a number of different reasons why this result may be true. First, people working in supervisory or director positions tend to be very busy. It is likely that many of them did not have the time to speak with Samantha. Second, if possible respondents were not familiar with CT-AIMH, they may not have known if the survey was coming from a credible source. In addition, some of the individuals contacted may not consider themselves to be providing infant mental health services, in which case they would not be part of the population we were trying to evaluate. Finally, blindly calling clinics and programs seemed to be less fruitful than calling a specific person at a location. As one might expect, leaving a message for the clinic as a whole made it easy for them to not respond. Using both email and phone calls to contact individuals, however, was particularly helpful because it provided people with different means to receive the information about the project, depending on their own personal preference.

A second limitation was the inconsistent structure of locations. Having such variability makes it difficult to make comparisons across different programs and sites; however, an alternative is hard to conceive while still being timely. In situations where numerous programs are housed within one clinic or site, it would take a director or supervisor too long to answer the survey about each program.

For a number of questions on the survey, lists were provided for respondents with an option to add anything that may be missing from the list. High response rates were obtained for most elements on the lists, and any others added to the lists were mentioned by relatively few people. The high response rates likely mean that the questions did address some of the most typical responses for those in the field, but it is also possible that some important elements were missed or underrepresented because they were not brought to consciousness for the respondent at the time of survey completion.

The possibility of missing some important elements of the field reflects the fact that there does seem to be a lack of consistency in how infant mental health is defined and what services and practices are essential to IMH work. As the field continues to develop, clarity is likely to develop. In the context of this survey, it seemed that the lack of definitions for which areas should be addressed and which services should be provided in order to be considered infant mental health work might have created some confusion for the participants. In creating the survey, there was not an entirely clear list of areas that should be included. Decisions were made based on familiarity with the field and ideas of what should ideally be included. There was also

likely somewhat of a selection bias in terms of those who were more familiar with the term infant mental health and what it entail were more likely to respond to our request.

This survey provides a strong starting point in the efforts to address the availability of IMH services in Connecticut. More data should be collected about what exact services are provided and which services are based on research and practice. Clearer definitions should also be established. Hopefully in the future a network of providers offering infant mental health services will be created, which will assist in referrals and create a collaborative community of mental health providers.

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Appendix A

Infant Mental Health Provider Survey

1. General Information:
    a. Program Name _____
    b. Individual or Group Practice? _____
    c. Which categories do your services fall into?
        - □ Prevention
        - □ Early Intervention
        - □ Treatment
    d. Setting in which your program operates
        - □ Private Practice
        - □ Child Guidance Clinic
        - □ Hospital- Based
        - □ College/University-Affiliated
        - □ Other _____
    e. Your position _____

2. How is your program funded?
    - □ Fee for service
    - □ Insurance ___ Husky Insurance
    - □ Grant funded
    - □ State funded (e.g. DCF)
    - □ Other _____

3. Do you (Does your program) serve children under the age of 5? Yes No
    a. Specifically:
        - □ Birth to one year
        - □ 1 – 2 years
        - □ 2 – 3 years
        - □ 3 – 4 years
        - □ 4 – 5 years

4. Do you (Does your program) also serve pregnant women? Yes No
    a. If yes, do you follow up after birth? Yes No

5. Where are you located?

    Location:

    a. Are there any restrictions on the communities you serve? If so, what are they?
    Communities:

6. What types of services do you (does your program) provide to very young children and families?
    - Assessment
    - Play Therapy
    - Parent-Child Relations
    - Parent-Child Psychotherapy
    - Parent Groups
    - Case Management
    - Consultation to Early Care Settings
    - Head Start
    - School Readiness Programs
    - Early Child Care Setting
    - Early Head Start
    - Birth to Three (Part C)
    - Home Visiting Programs
    - DCF
    - Family Resource Center
    - Other _____
        - Other:

7. Areas of Assessment
    - Social or emotion development assessment
    - Relationship assessment
    - Attachment Assessment
    - Relationship assessment for custody determination
    - Newborn Assessment (more than just medical)
    - Developmental Disabilities
    - Other:

    a. Do you use standardized tools? Yes No
    b. Which tools do you use with this age group?
        - CBCL
        - BASC
        - Vineland Scale
        - Bayley Scale
        - WPPSI
        - Mullen Scales of Early Learning
        - Parenting Stress Index
        - ASQ
        - ASQ SE
        - ITSEA
        - Interviews (unpublished)

- Observation
- Other:

8. Area of Specialization
   - Sensory Integration
   - Trauma
   - Behavioral and Emotional Issues
   - Developmental Disabilities
   - Feeding Disorders
   - Sleeping Disorders
   - Other _____

   a. Is there any specific model(s) used in your program?

9. Are you a supervisor? Yes No
   a. If a supervisor, who in your program directly works with families

10. Do you presently have a caseload of families? Yes No

11. What is your program's current caseload? _____
    a. How many 0-3 year olds? How many 4-5 year olds? _____
    b. Is there a waitlist to get into your program/become a client? Yes No

12. Do you offer or receive (or both) reflective supervision (i.e. An approach designed to help professionals consider – with someone else – their thoughts, feelings, actions, and reactions as they work to support the healthy development of very young children and their families. – Linda Eggbeer)? _____
    a. If you do not do reflective consultation specifically, do you do anything similar? What do you call it?

13. Can you encapsulate in a few words what your basic training for this age group has been? Specifically, your degree or credential that is most related to working with this age and then any other training (limit to 3 or 4).

14. For Supervisors: Is there a particular level or type of training required of your clinicians (family visitors, home visitors, etc.)?

15. Are there any eligibility requirements for a family to be part of your program/partake in your services?

16. Do you accept insurance? Yes No No Cost to Families
    a. If you do, which types?
       - Husky/Medicaid
       - Other