



# Minnesota Infant Mental Health Symposium Report

June 12–13, 2000

## CEED

Center for Early Education and Development



The College of Education  
& Human Development

UNIVERSITY OF MINNESOTA

Prepared for the Minnesota Early  
Intervention Team representing the  
Minnesota Departments of Health;  
Human Services; and Children,  
Families, and Learning





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# Minnesota Infant Mental Health Project

The Minnesota Infant Mental Health Project is a cross-agency initiative funded by the Minnesota Departments of Health; Human Services; and Children, Families, and Learning that seeks to establish and support a statewide framework of mental health services for infants, young children, and their families by enhancing existing programs and resources.

The Minnesota Department of Children, Families, and Learning funded this project partly in response to the provisions of Part C of IDEA, the Individuals with Disabilities Education Act. Part C is the Infants and Toddlers with Disabilities Program, which, among other things, includes in the definition of children eligible for service those who are identified as having “ a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.” The regulations give examples of these conditions, including “ severe attachment disorders.” Attachment refers to an infant’s relationship to adults who teach the child how to survive, both physically and psychologically. This vital, initial interaction between parent and infant sets the stage for him to develop healthy relationships and to grow toward independence.



# Infant Mental Health State Workgroup

**Lisa Backer**

Early Childhood Special Education Specialist, Minnesota Department of Children, Families, and Learning

**Sue Benolken**

State Program Administrative Coordinator, Minnesota Department of Human Services

**Betty Cooke**

Education Specialist, Minnesota Department of Children, Families, and Learning

**Martha Cramer**

Program Coordinator, Carver Scott Educational Cooperative

**Michael Eastman**

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Director, Children's Mental Health, Minnesota Department of Human Services

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Parent-Infant Specialist

**Barbara O'Sullivan**

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Teaching Specialist, University of Minnesota

**Terrie Rose**

Coordinator, Irving B. Harris Center for Infant and Toddler Development

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Education Specialist, Minnesota Department of Children, Families, and Learning

**Susan Schultz**

Psychologist, Private Practice

**Marty Smith**

Planning Project Manager, Minnesota Department of Health

**Christopher Watson**

Coordinator, CEED—Center for Early Education and Development

**Jill Weiss**

School Psychologist, Rondo Early Childhood Special Education, St. Paul Public Schools



# Agenda

## Monday, June 12

- 9:00-10:00 a.m.      **Coffee**
- 10:00 a.m.-12:00 p.m.    **Welcome and Opening Remarks**  
 Sue Benolken, Minnesota Department of Human Services  
 Michael Eastman, Minnesota Department of Children,  
 Families, and Learning  
 Christopher Watson, CEED — Center for Early Education  
 and Development, University of Minnesota  
 Marty Smith, Minnesota Department of Health
- Guest Speakers**  
 Martha Farrell Erickson, Director, Children, Youth,  
 and Family Consortium, University of Minnesota  
 Anne Gearity, LICSW, Washburn Child Guidance Clinic;  
 Adjunct Professor in Social Work, University of Minnesota  
 Gayle Hallin, Assistant Commissioner, Minnesota  
 Department of Health
- 12:00-1:00              **Lunch**
- 1:00-2:15                **Panel Discussion: Infant Mental Health Services**
- 2:15-2:45                **Break**
- 2:45-4:00                **Panel Discussion: Training and Systems/Organization**

## Tuesday, June 13

- 8:00-9:00 a.m.        **Continental Breakfast**
- 9:00-10:30              **Facilitated Small Group Strategic Planning**
- 10:30-11:00            **Break**
- 11:00-12:00 p.m.    **Facilitated Small Group Strategic Planning  
 (Continued)**
- 12:00-1:00              **Lunch**
- 1:00-2:30                **Recommendations From Small Group Strategy  
 Sessions**
- 2:30- 3:00               **Next Steps**



# Introduction

The 2000 Minnesota Infant Mental Health Symposium was held on June 12 and 13, 2000, at the DoubleTree Hotel in Bloomington, Minnesota, hosted by CEED — the Center for Early Education and Development at the University of Minnesota — and sponsored by a grant from the Minnesota Department of Children, Families and Learning. The Symposium brought together approximately 50 leaders from throughout Minnesota to discuss and plan for our state's approach to the issue of mental health in early childhood (see Attendee List in Appendix A).

Since 1994 the Minnesota Infant Mental Health State Workgroup has been meeting periodically to grapple with the growing concern regarding the mental health of our youngest citizens. In 1996, the Early Childhood Interagency Team, representing the Minnesota Departments of Health; Human Services; and Children, Families and Learning funded CEED to coordinate the Minnesota Infant Mental Health Project.

Working from the findings and recommendations of the 1998 Minnesota Infant Mental Health Services Feasibility Study produced by CEED and the ongoing work of the Minnesota Infant Mental Health Work Group, Symposium participants reviewed current service programs in Minnesota and produced recommendations for further steps in addressing the issues of service delivery, training, funding, advocacy and policy.



Ann Gearity speaking to Symposium participants.



# Monday Morning Session 1

June 12, 2000

***Christopher Watson:***

I'd like to welcome you on behalf of the Minnesota Infant Mental Health Project. I've been the Principal Investigator for the project since its inception in 1996, and I'm an employee of the University of Minnesota under contract with the Minnesota Departments of Health; Human Services; and Children, Families, and Learning.

We put this meeting together on a rather short timeline, and there was some concern as to whether people would be able to attend on such short notice. But, in fact, there's been an incredibly enthusiastic response, so I want to thank you all — the speakers, the panelists, and participants — for taking time away from your busy lives to be here. I think it's a testimony to the concern that we share regarding this topic.

Our work at this Symposium will be based on the accomplishments of the Minnesota Infant Mental Health Project, including the findings and recommendations of the *1998 Minnesota Infant Mental Health Services Feasibility Study* and its advisory group, the Infant Mental Health State Workgroup. The State Workgroup, begun in 1994, and the Minnesota Infant Mental Health Project, initiated in 1996, are sponsored by the Interagency Early Childhood Team.

Today we will hear about some of the existing resources and promising programs that are currently in place in our state. Working in small groups on Tuesday, we will produce recommendations for further specific steps in addressing the issues of service delivery, training, funding, advocacy, and policy related to infant mental health.

A report of the work accomplished at this Symposium will be published and distributed to key leaders, legislators, stakeholders, and others interested in the goals of the Minnesota Infant Mental Health Project. The recommendations brought forth at this Symposium will help guide future efforts to establish greater availability of mental health services for young children and their families in Minnesota.

It gives me great pleasure to introduce our first speaker, Martha Farrell Erickson from the Irving B. Harris Training Center for Infant and Toddler Development at the University of Minnesota.



**Christopher Watson, Martha Farrell Erickson,  
and Richard Weinberg**



**Martha Farrell Erickson**

## **A View of Infant Mental Health From An Education Perspective**

*Martha Farrell Erickson,  
Director, Children, Youth,  
and Family Consortium,  
University of Minnesota*

### **Martha Farrell Erickson:**

I am eager to hear what comes from this meeting. I really like the idea that you're all going to be working together to get your arms around this field of infant mental health.

It's a bit daunting to have someone ask you to represent the whole field of education. I don't think I can do that, but I did do a little thinking about what I think the educational challenge is as it relates to infant mental health.

The first challenge is raising awareness about what infant mental health is all about. It's a concept that is really foreign to most people in our society. If you were to imagine going up to the cashier at your grocery store, for example, and say that you work in the field of infant mental health, what do you think would be the response of that person? Bafflement. Your bank teller or your lawyer or your state legislator, perhaps, would have the same reaction. I think that reflects a deeper lack of understanding in our society about babies. We have a tendency to dismiss the validity of preverbal experience. Because language shapes our thoughts so much, society dismisses the importance and the impact, both short-term and long-term, of what preverbal infants are experiencing.

During a conference at which I was speaking recently, a psychiatrist was talking about the "lived experience" of babies. We were discussing things having to do with infants' intentionality and how parents or others sometimes interpret their behavior, sometimes underestimating their intentionality and sometimes overestimating it. But he used that phrase, the lived experience of an infant. I think that's a very important phrase to think about. To me, that's what infant mental health is about: the baby's lived experience. That, of course, is made up of all of those little day-to-day interactions, if it's a healthy, full-term baby who has moved home with the family that has given birth to him or her, and that baby is crying and waiting to see what the response will be; that baby is smiling and babbling and reaching out and waiting to see what the response will be; that baby is going to the doctor and maybe having scary, sometimes painful invasive procedures and getting a sense of who is going to be there to support him or her through that experience. All of those little things, day in and day out, make up the lived experience and, I believe, shape the mental health of that infant.

It's critical as we educate about the concept of infant mental health that we make a case to multiple stakeholders about the importance and, particularly, the

long-term consequences of infant mental health. As an educational challenge before us, I think that's one of the largest. We need to be looking, certainly, at decision-makers and policymakers, helping them understand how those preverbal experiences shape the lifelong patterns of that child.

We need to be considering the general public's understanding of infant mental health, in part because it's important for they themselves to understand, and also because they become a constituency that then informs and influences policymakers. To do that, we really need to look at how we can engage and educate the media about the importance of lived experience in infants.

I think to do that effectively, we need to hook our educational plan into the self-interest of those different stakeholders. What is it that they care about already? If they're not focusing on babies and lived preverbal experience, what is it that they care about? Are they employers who care about the readiness of the work force in the next few years? This is about infant mental health. Are there people who are really focused on the problems in our school system? Behavior problems in kids or the lack of school success and achievement? This is about infant mental health. Those phenomena have their roots in infant mental health. Is it people who are concerned about the lack of safety on our streets and the increase in youth violence or adult violence? That's about infant mental health. So we need to find what the self-interest is of each audience that we plan to educate.

We know that infant experience, the lived experience of babies, unfolds primarily within relationships. So infant mental health, to a very large extent, is in the hands of adults — those adults who are part of the daily life of that infant. Those relationships unfold within a rich and complex ecology of all of the forces that impinge on an infant and his or her caregiver or caregivers. So we really need to educate about the interplay of those forces, for better or worse, upon those relationships and therefore on the lived experience of the baby.

As we educate about the whole concept of infant mental health, the primary question that we need to pose to decision-makers and other stakeholders is, "Who is caring for the babies?" Who is shaping the lived experience of these babies? That leads me to several, very broad statements which have policy impli-



Jan Rubenstein and Tom Anderson

cations. I'll lay these out in broad brush strokes, but challenge you to think about these as you work through the next two days.

First of all, when you look at the question of who is caring for the babies, parents are, first and foremost. We really need to ask the hard questions about how ready are those parents to create a positive lived experience for their baby. Who are the parents who are not ready, and what are the reasons for their lack of readiness? How effectively do our wonderful programs here in Minnesota serve parents? And we have, in many people's eyes around the country and around the world, state-of-the-art support systems and education systems. And yet there are many parents who are slipping through the cracks and who we are not reaching because we don't have the outreach we need, we don't go through those windows of opportunity. So we really need to look at who are the parents who are not availing themselves of existing services, and what would be the strategies by which we could reach them and support them?

Those of us who are doing this work, and there are several of us in this room who have been involved in some very aggressive kinds of outreach work for very high-risk parents, know that this is very deep work that needs to address much more than just information for parents. It's not just telling them what babies need. It's not just educating them about the developmental stages and so on, but it really is looking at the support that's available to the parent, how they're dealing with the stress of their lives, the kinds of things that create stress in their lives, including such challenging issues as domestic violence, substance abuse, living in dangerous neighborhoods, high mobility because of the lack of affordable housing — any one of many issues that are a very real part of the lives of parents and, therefore, the lives of many babies.

We know also that this work really needs to take into account the parents' own history. The intergenerational research on attachment sheds a powerful light on the importance of remembering the past in order to be able to move beyond it. How do we, in our outreach to parents, come to grips with that, given that many of the professionals or paraprofessionals who are doing family support and education are not trained as therapists? They don't have a great deal of education or training in how to process those complex kinds of psychological issues that have to do with a parent's own history. Yet, they're in a very powerful position to share that journey with parents as they look back, so that they can move forward. How can we define and shape our programs so that we reach the hard-to-reach parents and do the work that is deep enough and sustained enough and that comes about in the context of relationship-based work? The other thing we know is that it's not just about having a curriculum or a strategy or a trick that's going to do the work, but change happens within the context of relationship. So I challenge you to think about that.

What kind of training or education, ongoing support, and consultation is available to the professionals and paraprofessionals who are doing that work, knowing that it takes a huge toll on the providers? How are we creating systems that provide the kind of personal emotional support for people doing that hard work and the kind of deep consultation that will enable them to really grapple with the psychological and social complexities of the lives of those parents?

We also need to look at other caregivers, in particular our system or lack of a

system of early care and education. The majority of babies are spending at least a portion of their lives in out-of-home child care. We all know the range in terms of quality, consistency, and readiness of the people who are doing that work, and the high turnover in child care settings, which is, to a very large extent, a function of low wages. In fact, the Department of Defense did a very interesting renovation of their systems where they doubled the wages of the workers in their child care centers within their department. Within one year, turnover dropped from 40% to 6%. That says a lot about continuity of care, which is a critical factor in the lived experience of infants. So we really need to come to grips with this whole range of child care options for our children and hook up with the people who are often outside the defined field of infant mental health, but people who are really working on finance, training, and quality issues in early care and education.

What else do we need to look at? We need to look at our health care system. I know we're going to have another speaker talking about that, so I won't dwell on it. But I think the health care system is the one place that babies and their parents almost universally come in contact with. Yet, that system is really strapped for all sorts of economic reasons. We need to look closely at how the health care system, and people working in that system, can be attuned to the early indicators of infant mental health. That means having a good deal of understanding about what to look for both in the babies and in the caregivers, the parents in particular, and in the space between the baby and the caregiver. Then, if that system is able to look at the indicators, they need to do something with that information. Where are the resources for those infants and families who need intensive intervention — professional, psychotherapeutic intervention, in many cases? Do we have enough people within our mental health system who are prepared to work with parents and babies? I know we have a few in this room who have specialized in that, but my sense is that we are really short on people who understand the nature of that specific work. If we have enough people to do it, who's going to pay for it?

I would leave you with the thought that this last question — who's going to pay for it? — is a really critical question. If no one is paying for it now, I think we can be assured that we all will pay for it later. That takes me full circle back to where I started. That is the message that needs to get out: The link between infant mental health, early lived experience of a human being, and later outcomes and the cost of those outcomes if we don't invest up-front. I look to you for all kinds of good ideas about how we can move forward with this. How can we really join forces and be advocates and educators, creating opportunities for babies to have the lived experience that they deserve? Thank you.

***Christopher Watson:***

Thank you so much, Marti. One of the concepts behind this meeting is that it's a culture-building experience. Identifying and hearing from leaders like Marti Erickson — and all the rest of you who are present — we hope to create a synergy around the issue of infant mental health that will assist us in moving forward. Susan Schultz is going to introduce our next speaker.

**Susan Schultz:**

Our next speaker is Anne Gearity. Anne and I have shared office space and have been colleagues for almost 15 years. She is a clinical social worker who has both a very extensive mental health practice and also a community practice. She is a sought-after consultant to many programs and also speaks around the country and teaches at several institutions of higher education here. I don't know if any of you have heard Anne speak before, but she is a gifted speaker, transforming theory into practice. Today she is going to say a little bit about human services. She is a clinician who also has a vision of policy and service organizations.



**Ann Gearity**

## **A View of Infant Mental Health From a Human Services Perspective**

*Anne Gearity, Washburn Child Guidance Clinic; Adjunct Professor in Social Work, University of Minnesota*

**Anne Gearity:**

I'm also here standing in for Esther Wattenberg<sup>1</sup> and I'm really honored to stand in for her. She would be much more facile at content about human services. I've

been working with Esther for many years, very informally. Esther has been a wonderful testimony to a quick study, because her area is not mental health. Because of my teaching at the University, I would periodically nudge her about mental health. A couple of years ago, she started hosting salon lunches. There would usually be eight or ten people, and Susan and I were often among them. She'd gather people together and essentially say, "Tell me what I'm supposed to know." We would sit around the table and balance our lunches from the campus center and tell her what she was supposed to know. She has really been a bridge between the human services system and mental health. Out of these salon lunches, two projects happened this year, so I wanted to start with the focus on these projects.

One was with Christopher's help. Esther asked Kathryn Barnard, who was here for the Round Table<sup>2</sup>, to come and give an afternoon talk about infant mental

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<sup>1</sup> Esther Wattenberg, Director, Center for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota.

<sup>2</sup> The 1999 Minnesota Round Table, presented by CEED, addressed the topic of "Observation and Assessment of Young Children: Issues in Research, Policy, and Practice." Round Table Speaker Kathryn E. Barnard, is a professor with appointments in Parent-Child Nursing, Psychology, and the Center for Child Development and Mental Retardation, University of Washington, Seattle.

health designed primarily for child protection workers. I was the respondent of that talk. Esther expected 35 people but, in fact, 200 people attended. We were still turning away reservations in the days before the event. We were quite stunned by this turnout. Out of this project, Esther gathered some funding. This spring, Marti Erickson and I were part of a teleconferencing panel that was organized by Esther Wattenberg and Sandy Robins in the School of Social Work. We had a two-hour teleconference with 80 of the 87 counties in Minnesota. It was set up so that four very typical and difficult cases were prerecorded by child protection workers and were available for us and the counties to see. Then there was a system where we could get questions from the various counties. They were brought into us and we could respond. It not only went out to the 80 counties but to several states and countries.

There was tremendous interest in our focus on infant mental health and looking at cases where there were children under age three involved. These were very typical and difficult cases. The response and the feedback was very interesting. In some counties, there was delight and great appreciation for a more psychological and clinical lens. In other counties, there was a sense of despair. What they needed was more training on the regulations: "Tell us how to do it."

With that as an introduction, let me comment on human services. There are several issues that I think we need to be thinking about when we think of the human services/social services system. One is that, until recently, the focus of child protection services in the larger human services system has not been on the very young child. This is a new paradigm for that system. Even still, we are primarily addressing the needs and deficits of the adult parent or the needs and deficits of the family system. There is significant need to train workers in the social service system in using this lens of early brain and relationship development. Just as Marti said that this is unfamiliar to your banker, it's also familiar to the bulk of the social service system. This has not been their training or their foundation.

Secondly, the child welfare system has been inundated with very young children, made significantly vulnerable by prenatal exposure to chemicals, to early attachment disruptions, or to trauma involvement. These children are in our system and we have few ways of understanding them, much less dealing with them. The system right now is overwhelmed by the needs of the children that are coming into it, and the physiological complications of these children are well beyond our understanding heretofore. We don't know how to remediate these difficulties. Some of these children are older children who are experiencing profound adult mental difficulties related to their early developmental crises.

I know these children as a clinician and have observed the devastation in their now-lived experience. Part of my work at Washburn Child Guidance Center is trying to develop models of day treatment for preschoolers and elementary-aged children who come in with these kinds of early developmental deficits, now made more complicated by the demands of continued living. We know these children are in our system. We know the system does not know how to respond. We know the system is responding in ways that are inadvertently adding to these children's harm rather than interrupting it.

Thirdly, the system is already overloaded. This is a reality. There is a diminished number of foster homes compared to the need. There are diminished tangible



David Fisher

resources available. There is a shift in child protective services from a proactive, supportive model to a litigious model. More and more cases are being evaluated in terms of whether or not they meet criteria for litigation. There is very little of the kind of support that many of us grew up assuming child protection would provide. I hear constantly from community clinicians that they call child protection looking for help and are told that it's not a reportable situation. This is very real. There's growing economic disparity, and there is increased use of community members as staff and paraprofessional staff with limited training. Our system, in and of itself, is not resource-rich.

Lastly, I want to identify training issues from the human services system perspective. Training has traditionally focused on social support systems and sometimes family systems. This has certainly been useful training, to a point. It

has not been a training model based on psychological systems or intrapsychic systems. If we are to move to an infant mental health lens, we have to ask how are we going to train to the idea of intrapsychic systems and shared intrapsychic systems. How do we train workers to think about not only what the mother is tangibly doing to the baby, but how the mother/baby interaction, in fact, is creating an internal structure in that child that will become useful and perhaps permanent? How do we explain such intrapsychic systems in ways that make knowledge accessible and not frightening to community staff? How do we realize that this material is stirring and evokes defenses and reactions of helplessness, burden, and denial? How do we construct a system that helps workers? Many of us who have done community-based training know that we can have lovely models, but we present them in a way that frightens our staff rather than making them feel more effective and efficient, and they shut down. Then we're back in a very stuck position.

I've been working on a project this past year with a group of people in Chicago, looking at training. We spent about 20 hours pairing a group of clinicians with a group of policy people. We talked about how do you think about training from a policy perspective and from a clinical perspective? We tried to find shared language and shared ideas that allowed us to influence one another. It was actually a wonderful experiment to realize that we had to get out of our traditional language models and find a new language that allowed, as Marti said, the different constituents to work together. I hope that we can do that today.

Certainly, Marti has covered most of the things I would wish for us, too. One is that we need to create a culture of infant mental health. This is the time to do it. Most people have read in the popular press about the impact of early development and, as adults, are actually curious about their own impact. But as a culture, we have not shifted to thinking about that proactively and preventively.

Secondly, I would urge that sometime in these two days we discuss what our community stand will be regarding the current child protection crisis. I'm going to name it as a crisis. We have shifted radically from how we perceive child protective services in the early 70s to how we're now perceiving it in the early 2000s. We have a system that is not serving the community in the proactive way that we wish, and we have clinicians who are regularly feeling they cannot turn to child protection for help. So as a community, I think we need to have community discussions about what are our community standards. How do we want to see those enforced? How do we want to support child protective services so that they're not standing alone in this litigative process? What is our community standard going to be?

Thirdly, and Marti touched on this, I think we have to look at how we can develop complicated training that takes into account development, motivation, learning, and adult experience. How do we develop these training modules in the vernacular of the community so that we can increase people's sense of competence and efficiency? How do we as the experts, translate our clinical knowledge so that it doesn't frighten workers?

One outcome of this meeting is to come up with some grand ideas that don't have our child protection and human services colleagues feeling yet more burdened. I think that's often been the response. They go to workshops and they leave feeling even more incompetent and less knowledgeable about how they're supposed to do their job. I'm assuming that most child protection workers are graduate-level social workers, and yet we know that's not true. Some of the non-graduate-level social workers have more than a prior degree in experience, but yes, having a systematic way of thinking is not available to most line staff. So I'm going to represent the line worker who has two years of masters-level education with, if she or he is lucky, one course in child development. The course I teach at both graduate schools of social work in the Twin Cities is the only course offered in child development. In 14 weeks, I not only teach development but intervention, assessment, case planning, and advocacy. One course. So how do we develop training modules that are very focused on what workers need and help them feel less burdened and more efficacious?

Lastly, how do we influence the human services system, including the legal system and the legislative system? How do we organize our results in order to have impact on legislators and the legal system so that there's some shared language? When we talk to county attorneys, their understanding of our task is very different than our understanding of our task. How do we extend our focus to them? Thank you.

***Participant:***

What is "intrapsychic"?

***Anne Gearity:***

See, I've already slipped into my jargon! "Intrapsychic" means we look at interpersonal — how I relate to you. We look at environment — how I experience my world here today. Am I cold? Am I hot? Am I enjoying the room? But what we're

really looking at when we talk about infant mental health is how the baby takes in a lived experience and turns it into what we call “inside structures.” So Marti, the attachment theorist, would talk about an inner working model. Where the inner working model lives is some complicated collaboration between my brain structures and my mind work — the meaning I give it.

Trauma research is very helpful to us because it allows us to see how very young children take in an inner working model or a state of arousal and turn it into “that’s the way the world is and that’s who I am, aroused.” “Intrapsychic” means inside my psyche, or inside the part of me that is a collaboration of physiological arousal and the meaning I make of it. We have children who have an intrapsychic structure that says the world is a dangerous place, people hurt me, and no one will help me. That’s inside them. We know that we can meet those children and say, “You’re mistaken; the world really is a lovely place and I like you.” But that is not meaningful to them.

***Christopher Watson:***

Thank you very much, Anne. Marty Smith will introduce our next speaker.

***Marty Smith:***

It is my pleasure to introduce Gayle Hallin, who is Assistant Commissioner for Community and Family Health at the Minnesota Department of Health. Gayle brings to the Health Department a wonderful grounding as former director of public health in Bloomington and many years of experience working as a public health nurse doing what many of us are talking about today — going into the home to work with families and working in the community. She has a sound understanding of how things work in a local community and is bringing that to help us at the Health Department.



Gayle Hallin

## A View of Infant Mental Health From a Public Health Perspective

*Gayle Hallin, Assistant Commissioner  
Minnesota Department of Health*

### **Gayle Hallin:**

Thank you, Marty. It seems that this is an opportune time related to mental health. This is the first time in the 24-plus years I've been in public health that mental health has been coming up to the top in the public health community. We have, this very day at this very time, people at our department meeting with the Department of Human Services and the Department of Children, Families, and Learning to plan some community forums on infant mental health. We also have some joint meetings going on between the commissioners in the Departments of Health; Human Services; Children, Families, and Learning; and Corrections. We're looking at the ways in which we as State departments can better understand the whole of mental health and our particular goals and relationships with mental health.

We're often thought of in health as the health care system. Our commissioner will readily say that health insurance and the health care system is a necessary component for health, but certainly insufficient to achieve health. Yet, we spend 97% of all of our health care dollars within the health care system, leaving only 3% for prevention. We know that's out of balance. We have an opportunity with our commissioner's and governor's interest in reframing our health care system in the next 50 years to look at how we can better invest our resources in moving upstream and, essentially, saving money in the long run. But beyond saving money, having a healthier population.

We also know that with one of the other priorities at the Department of Health on eliminating disparities in health status, we have a major challenge in this state. When we look at our health indicators for the state, most of you know we always come out number one on the Reliastar health ratings. Many of you also know that when we break out the averages, Minnesota has the highest gap in health disparities between populations of color and the white population. The issue of disparity is huge as we think about mental health and infant mental health. What is it about our environments that create toxic kinds of environments, particularly for young children? I'd like to share an analogy because I think it's relevant in the children's mental health area and also relates to our role in public health.

When you walk in a vineyard, you can smell all the different things that are planted around particular vines. What's planted around the vine changes what each wine becomes. There are some things that we know about genetics and there are some things we know about environment. There are some things we



**Connie Abbott**

have control over and there are some things that we don't. What we need to do more intensely is to understand those conditions around and within people about which we know can make a difference, that we have the power to change. We need to understand what you can do to plant the kinds of things that make a difference in the health and well being of children, in this particular case, infants.

The Institute of Medicine Report defined public health as "what we as a society do together to assure the conditions in which people can be healthy." Public health is about understanding what those conditions are and doing the research to investigate potential outcomes of those conditions. Public health is much more than a health care system. Public health works to ensure health care access;

making sure that people can get in for care; but even more importantly, it's about working with individuals, families, communities, and systems so that people understand what it is we have the power to do to improve health and well being for families, children, and infants.

In that regard, I'd like to share just a few initiatives that are relevant for today. Linking with the importance of public policy, this past legislative session dedicated a portion of the TANF money (Temporary Assistance to Needy Families), \$7 million a year over the next three years, to home visiting — using the public health nurse home visiting model that incorporates health and mental health components and integrates these with the family's move toward self-sufficiency. It is an example of how a collaboration like today's meeting, which brings together the different disciplines, can look at how together we can work on a model to claim success and, with it, be able to demonstrate to our state legislators, its value. The legislature has given us a three-year timeframe, and they're going to be looking at what we can show in the way of not only the health of the families and the children, but the benefits economically to the state.

At the Health Department, we also have staff provide training and consultation for public health nurses and other providers around the state on doing in-home assessments of parent and young child interactions. We also are involved with the Tracking and Follow-Along Programs so that we can follow up with families with home visits and connecting people with services in their community. We're also hoping to enhance our abilities to work across State departments to give more resources to prevention and early intervention. I really think that's a part of what this Symposium is about, and I would hope that today's outcomes will help frame some of the policies about how we invest our resources and our time in the future. So thank you for taking the time to be here, and I look forward to what we get from the meetings and your continued investment in mental health needs. Thank you.

# Monday Morning Session 2

June 12, 2000

***Christopher Watson:***

I would like to introduce Michael Eastman from the Department of Children, Families, and Learning, and Sue Benolken from the Department of Human Services.

***Michael Eastman:***

It's important that you all know that Sue and I represent the area of disabilities. We are a part of the early childhood intervention system which includes the Part C program that serves infants and toddlers with disabilities and the preschool program for children with disabilities. That is how we have, over the past four or five years, presented ourselves as we've tried to always express the interest in young kids with disabilities and see that they are indeed involved in however infant mental health is proceeding in Minnesota.

Today we are going to share with you how, since 1994, our two agencies have moved into this arena and have worked with CEED as the original funders of the Minnesota Infant Mental Health Project.

We all know that universities are, of course, the sacred ivory towers that do all the thinking, and the rest of you are the field which do all the work. So what does that leave for State agencies? It's still kind of a mystery to us, but we're going to try to present how we think our world has unfolded. We're going to go through a series of e-mails that we have been sending back and forth to each other for years.



Michael Eastman, Ann Gearity, and Sue Benolken

I'm going to start with our very first e-mail, which came about in February 1994. It's from me, so I'll read the e-mails that are from me and Sue will read the e-mails that are from her. We hope this kind of simplifies things. Any questions so far?

February 1994: Dear Ms. Benolken, I'm so happy to be here in Minnesota. The State bureaucracy in California is unbelievable. It is nice to be able to actually do something in a State agency. Say, want to start an infant mental health project?

***Sue Benolken:***

February 12, 1994: That's a wonderful idea. I'll recruit a few players from here at DHS and we'll have a meeting later this week. How about Friday at 4:15?

***Michael Eastman:***

February 20, 1994: Dear Sue B., What a great meeting. We were able to identify so many of the components that need to be developed within this system. For example, the definition of infant mental health, eligibility criteria, services, personnel, funding, and the list goes on. But don't you think it's a little unusual that we were the only two people at the meeting?

***Sue Benolken:***

February 22, 1994: Michael, Oh no. We often have meetings when no one shows up. Is it any different in your agency?

***Michael Eastman:***

February 23, 1994: Sue, I guess I never thought of it before. Let me hold the next meeting, okay?

***Sue Benolken:***

February 23, 1994: Yeah, whatever.



Michael Eastman

***Michael Eastman:***

March 2, 1994: Dear Sue, You're right. Having a meeting with State staff is complicated. I can't even get a meeting room until next month.

***Sue Benolken:***

March 10, 1994: Hey Michael, here's what we're going to do. We'll invite the staff from the Departments of Education and Human Services and get their reactions to our thoughts and ideas. We'll have it on Tuesday and provide snacks.

***Michael Eastman:***

March 10, 1994: Dear Sue. Oh no, Sue. We can't get snacks if the meeting is for State staff only.

**Sue Benolken:**

March 11, 1994: Michael, my group is so great. I'll pay for the snacks myself.

**Michael Eastman:**

April 22, 1994: Dear Sue. What do they mean mental health for infants? I thought we were going to talk about the service. Infant mental health for young kids with severe attachment disorders or problems with relationships. We are using Part H special education dollars, so we have to stay within the limits of infants and toddlers with disabilities.



Sue Benolken

**Sue Benolken:**

April 30, 1994: Michael, that one caught me off guard too. I think the group was trying to articulate the issues that we have in Minnesota with children's mental health in general. As it is, we don't have some of those issues figured out. Issues of wellness, prevention, and intervention are a long way from making sense in the context of infants and toddlers with disabilities.

**Michael Eastman:**

Now we move to 1995. March 5: Okay, here's what we're going to do. We'll issue an RFP and make someone else figure things out. How about a six-month timeline? That's enough time for somebody to figure out what other states are doing, what's happening here in Minnesota, and make recommendations on a model that includes an infant mental health definition, services, eligibility criteria, personnel qualifications, and funding. And oh yeah, how about leadership from a State agency perspective? Let's have that recommendation too. I bet if we get this going, by the time the legislature is in session, we can get some support and who knows what will happen next, right?

**Sue Benolken:**

May 25, 1995: Michael, yup, that's the way it happens around here...in your dreams.

**Michael Eastman:**

June 30, 1995: Sue B. Say, what do you think about CEED? What does that stand for anyhow? Center for Educational Excellence and Diplomacy or something? I'm never going to get this state figured out. How can 694 go east and west as well as north and south? And how can one say everything south of the river when the river itself runs north and south? Anyhow, CEED is the only proposal we got. I wonder what that says.

***Sue Benolken:***

December 20, 1995: Michael, I guess that six-month timeline didn't work out so great. Seems like we need a little bit more time. What do you think? And how about a visual that will help explain the service intervention that we're talking about?

***Michael Eastman:***

January 5, 1996: Sue, sorry about not getting back to you sooner. Things kind of got away from me with the holidays and all, but it's time to get to work here and figure out what's with infant mental health. I still don't think that people understand that we are talking about children with disabilities and that intervention is the service.

***Sue Benolken:***

February 12, 1996: Michael, okay. It's time we back off and let CEED do things this year. That survey is going to answer many of our questions, so let's sit back and wait for answers. Once that is completed, we'll bring the state group back together.

***Michael Eastman:***

March 5, 1996: Sue B. Sounds great to me. It's time to wait for the information and outcomes of the survey and take it from there, and that's where we are now in terms of handing this off to the work that has happened at the Center for Early Education and Development.

***Christopher Watson:***

Thank you, Michael and Sue. Following that creative presentation of the origins of this project, Marty Smith and I are going to hopefully bring you up to date as to what's happened since. We did go through a process of, first of all, trying once again to decide what it is that we're talking about when we say "infant mental health." We brought together a group of 12 consultants from a diverse set of responsibilities and agencies, including a parent and a number of different programs. Some of those folks are here today. We spent, by my estimation, about three or four months trying to work out the definition. We would meet one weeknight a month in the dark of winter and discuss "What is infant mental health? How do we define it? How do we get our arms around this very big concept of infant mental health?"



**Christopher Watson**

Our first attempt resulted in a dense, full-page definition, which was our working definition for quite awhile. When we started showing

that to people in our respective fields, there was a lot of confusion. There was a lot of feedback that it was fine for an exercise, but in talking to most people, we needed something that was more concise. So this is what we ended up with —

*Infant mental health* is the optimal growth and social-emotional, behavioral, and cognitive development of the infant in the context of the unfolding relationship between infant and parent.

This is, to this day, what has guided us in terms of the definition. This is included in the Executive Summary of the Feasibility Study. The important part here for us — it was in the very beginning and is still — is this phrase: “the infant in the context of the unfolding relationship between infant and parent.” A lot of people today have already talked about how important that is and the various ways that different professionals have of approaching the parent/child relationship or caregiver/child relationship.

Our team of consultants was also mindful that when we talked about infant mental health, we were talking about a number of things at the same time. Roughly speaking, the way that they could be broken down or grouped, at least in my mind, was in this way: First, there was that public health prevention part of infant mental health that was referred to, particularly by Gayle Hallin this morning, in terms of all the factors that go into supporting the healthy development of children.

The second piece is the therapeutic intervention that both Marti Erickson and Anne Gearity spoke to, where there is a specific intervention that happens when the supportive environment for the child is not there.

The third piece, which kind of brings the whole family together and gets everybody linked, is the concept of relationship-based services, where infant mental health as a philosophy and as a way of working with families really has as its core a very basic, and sometimes very different, founding theoretical and practical approach to working with families and their babies. It is sometimes, as I say, antithetical to the training we each have received in our respective fields. It has to do with, again, a relationship. If you were traditionally trained a number of years ago, you might have experienced a very different approach to your work with families or even young children, where relationship was not at the forefront and was not even part of the equation. Skill-building was really the focus, without so much as a nod to the relationship that you have with the child and the family as you go about that intervention or that work with them.

So, as Sue Benolken has talked about it, infant mental health is like an accordion that can be expanded or pushed together into a compact object. The accordion of infant mental health expands to include a lot of people, a lot of efforts, and a lot of activity that come under the rubric of infant mental health. That's why it's so confusing to people, because it is so big and yet can be compressed to a relatively focused intervention piece that we sometimes refer to as infant mental health services.

So the big questions that we asked are the ones that you've already heard about today. When we looked at doing a feasibility study, our aim was to figure out what Minnesota has going for it. As has already been referenced, when we

talked to other people from other states, they look at us with a great deal of envy and for guidance, because we have so many resources here. We have them at the University in terms of research and the application of research-to-practice; we have them in our State agencies in terms of leadership; and we have them at our community, government, and agency level in terms of programming for families. So we have a lot of resources. From the outside, it looks like we've made it and we have a lot of good things going on.

But those of us working within systems know that a lot of us are not connected and that there are important pieces missing. Our project developed a framework in an attempt to assess what we have and what's missing, what's not in the picture. What does Minnesota not currently have in terms of resources, training, etc.? We asked a number of questions that have already been referred to, starting with what families and children need in this new age, in this place in our society and our history. Who is and should be responsible specifically for infant mental health? Who owns it? If no one owns it, then who's in charge of making sure that it's a top priority? Who provides services? How are services identified? What kind of training is necessary for service providers? How is it decided who receives services (that's getting at the criteria issue)? Who pays for the services? Finally, in the Minnesota tradition, we were very careful to make it clear that we were not going to be going in as a State and dictate to local communities what should or shouldn't be a part of their systems or their activities, but in fact we were wanting to enable and build capacity locally. So it wasn't about imposing one particular structure or point of view or program idea, but really taking stock of what strengths communities already have and asking them what we can do statewide to help them build their own capacity in their own individual and unique way.

I'd like to spend a few minutes discussing approaches to the way we conceptualized infant mental health when we try to put it into a schema or a conceptual model and diagram (see Appendix B). The largest circle refers to the general population where we would focus advocacy and public relations efforts. The second slightly smaller area includes families with young children. Within that context, general education and support is provided as a society and culture for families with young children. Lastly, we have this other big circle that contains two circles with movement back and forth. In that circle, we have families who require more intensive intervention. The reason for the two circles is that, in our scheme of things, we have two levels of service. One is more intensive than the other. The idea is that families, in the best of all possible worlds, could travel back and forth into center-based programs and other kinds of family support programs and get the kinds of service and levels of service that they need. You then have fluidity of movement between the most intensive and the moderate-level services and support systems.

Our Feasibility Study consisted of many different steps, including getting input from local community providers through a statewide mail-in survey. We also conducted five focus groups around the state. We used the IEIC structure (Inter-agency Early Intervention Committees) to do those focus groups. Then we conducted individual targeted interviews with a number of people working in differ-

ent environments and systems to find out what kind of impact the infant mental health service framework and training could have on them in their work.

Some of the results, in terms of our questions about services, will not be a great surprise to a lot of you. Services for the following received the most “Don’t Know” responses with regard to whether they are sufficient:

1. Infants that experience hospitalization that causes separation from the parent
2. Infants who experience trauma
3. Relationship problems between infants and their caregivers

“Relationships between infants and their caregivers.” There’s a lot of concern from many walks of life and professions in terms of that relationship piece.

In response to the question regarding the availability of services for parents who have emotional problems or mental retardation, most communities said “No,” significant services were not available. So here’s another situation where we may have some specific services for parents but little or no focus in terms of looking at how they can parent and building their capacity to parent and supporting them in that process.

Finally, I think this quote from a parent sums up what both providers and parents told us. What they envisioned as the Utopian dream for infant mental health services would be a “smorgasbord of possibilities where parents could fashion their own services. The idea that ‘one size fits all’ does not work.” That is, one intervention or program or service is not going to fit the needs of every family.

The Feasibility Study team of consultants came up with a list of recommendations. These are detailed in the final report and include recommendations for education and support, advocacy, developing training systems, building capacity, what the state should do, what we all can do, what our places are in this big scheme of things.

Today and tomorrow, what we want to do is take the next steps. We have a list of general, broad-based recommendations. This afternoon we will start out looking at what we have in Minnesota and the kinds of strengths that we bring to this topic and then go one step further with the recommendations and other ideas that have come to the surface in this process. Marty is going to talk a little bit about the process that we’re engaged in for these next two days.

***Marty Smith:***

I would like to talk to you a little bit about how we got here today. We have a comprehensive feasibility study and recommendations. We have a stakeholders group that gets together and talks about where can we go as individual entities. But what’s the next step? What can we do to move an infant mental health agenda forward? What can we do to move the system forward? We decided it’s time to bring together people who are involved at the community level, the interpersonal level of working with families, whether it’s in the home or a clinical setting or school setting or child care, and gather your expertise to guide people who are in policy- and state-level positions who can then help to shape policy and programs. That’s what we’re here to do over these next two days. We’d like



**Marty Smith**

to create a culture around infant mental health, to appreciate what each of you is doing, and to look at what are the gaps, what are the barriers, what are State systems and policies doing to enable you to do your work, or what are we at the State level doing that makes it harder for you to do your work? What kind of supports do you need?

We have some steps that we want to go through to get to that goal. This afternoon, we'll be hearing from people working in some innovative programs and service systems in our state. Tomorrow, we'll break down into four different work groups to address specific components of a system of infant mental health.

What we'd like you to do is review the feasibility study and the recommendations from the vantage point of your experience, and develop strategic

directions and recommendations for us so that we can move forward in implementing some of the recommendations. One of the key issues that we've struggled with and that we'd like your help with is how do we talk about infant mental health? Anne spoke about that this morning. How do we talk about it in a way that's meaningful for people? How do we include young children beyond infants or babies in the discussion? What's our scope here? How do we do it in a way that makes sense to people and that grabs them, so they understand the implications of this kind of work or the implications of not doing this kind of work?

We want you to help us develop strategies so that we can reach out to multiple stakeholders. Marti Erickson spoke about some of those stakeholders — policymakers, service providers, the general public, employers, media, and the court system. How do we begin? What should our top priorities be? Interest in issues around children's mental health, at least at the state level, is growing. There is concern about more than the deep-end kids who need services, but also looking at prevention and early identification and early intervention. What would be the role of infant mental health in that?

***George Realmuto:***

I'm not sure you're entirely correct in saying that early intervention and prevention, in terms of children's mental health, has a constituency in the Department of Human Services, perhaps not in the Department of Health, and perhaps not even in the service providers, perhaps not in the state itself.

***Marty Smith:***

I agree, and that's what we're here to talk about. I know that the Health Department has been asked by Children's Mental Health and DHS to look at prevention and early intervention. This is new ground for the Health Department to get into, to even think about what is the role of public health, in mental health in support-

ing the well being of people across the life span. I do agree, though, that there has not been that kind of focus; the focus has been more on real deep-end kids and issues.

I'm hoping that we can develop multiple perspectives from a policy viewpoint and a clinical viewpoint and a direct program and service viewpoint in terms of what is it that we need to do in our state for infant mental health. Now is the time for action. What I'd like to see come out of the Symposium are specific strategies and recommendations for what actions and strategies need to be taken to begin to move forward. Who do we align with in the legislature? Who do we align with within the community in terms of service providers? Who do we align with in business? Who do we align with in media? Looking at our audience today, I think another critical issue is that we need to figure out ways to be more inclusive in our discussion. There are many, many people working in Minnesota with a wide range of communities, families of color, as well as recent immigrants. What is our involvement with them? How are we reaching out to them and learning from them about what the issues are and what some of the cultural dimensions are? What are we hearing from families? Do we have family representation in the development of services, in the evaluation of systems, and helping to drive policy?

I'm hoping that those are all the kinds of things that we can come up with. Again, I think it's time to quit talking about the issue and develop some real strategies to move forward.

# Monday Afternoon Session

June 12, 2000

*Christopher Watson:*

Before we begin the panel discussion, I've asked Glenace Edwall to say a few words because she's in a new and important position in the State of Minnesota. She can tell you about her thoughts about what we're doing here and how important it is to her and her work.

## **Glenace Edwall, Director, Children's Mental Health, Minnesota Department of Human Services**

*Glenace Edwall:*

Christopher asked me to say a couple of things because I think my background is really relevant to infant mental health and I am doing everything I can to help promote this. I am almost a month into my new job as Director of Children's Mental Health at the Department of Human Services. I came most recently from Fraser Child and Family Center in Minneapolis.

I'm a child clinical psychologist by training and went through a wonderful program at the University of Denver that had courses on preschool personality and social, emotional, and cognitive development. So I really had a very thorough grounding in some of the things that we're now addressing. That, in turn, built on a background at the University of Minnesota where I came from a very interesting psychology program in child development, experimental psychology, and educational psychology. All of this is near and dear to my heart. I told people



Barbara Belzer, Scott Harmon, and Glenace Edwall

when I interviewed for this job that if there was one content area that was really important for me to advance, it was infant and preschool mental health. So I'm really very much with you.

## Panel 1 Discussion

Representatives from a variety of community programs were invited to participate in two panels. The facilitated sessions offered them the opportunity to talk about their activities that support families with young children. Attendees were invited to ask questions about the programs.

### Moderator

Betsy Horton, State Infant Mental Health Workgroup Member

### Panelists

Tom Anderson, Family Resource Worker, Southwest Family Room

Cindy Toppin, Vice President Lifetrack Resources — Early Head Start

Chris Hansen, Early Childhood Special Education Teacher, Carver Scott Educational Cooperative

Rene Torbenson, Parent/Infant Specialist, Early Childhood Family Education

Sandra Hewitt, Child Psychologist, Private Practice

Beth Vossen, Dakota County Social Services

Terrie Rose, Coordinator, Irving B. Harris Training Center for Infant and Toddler Development at the Institute of Child Development, University of Minnesota

Martha Schermer, Social Worker, Children's Hospitals and Clinics, Minneapolis

Gary Schwery, Therapist, Psychomotrist, Associated Clinic of Psychology

(See Appendix C for panelist background information.)

### *Christopher Watson:*

Now I'd like to introduce Betsy Horton, who's agreed to moderate our first panel this afternoon.

### *Betsy Horton:*

Thanks, Christopher. I'm a clinical social worker and, as I've watched kids over the last 20 years or so that I've been in this state, I get more and more worried about the kids that fall through the cracks.

I'd like to begin by looking at the continuum of service model (see Appendix D). We've used this model in the State Stakeholders Workgroup. We've attempted to include panelists who represent a variety of points on the continuum to speak with us this afternoon. I'd like to ask each of you to tell us a little bit about what is really exciting about the program you work with; what are you doing that's working; what are some of the challenges you're facing? If you've developed something innovative, let us hear what it is. Martha, will you please be the first to tell us about your work?

**Martha Schermer:**

I work in the NICU, which is the Neonatal Intensive Care Unit and in the Infant Care Center (ICC), which is a step-down unit. The families that we work with have infants that are hospitalized, either due to premature birth or some other congenital anomaly which necessitates them staying in the hospital before they are ready to go home.

Some of the families that we work with are healthy families that have had a very unfortunate situation happen to them and their baby is in the NICU. We have other families that, for various social reasons, are having many more problems. So depending upon where the family is, they could be at any one of those areas on the continuum of services.

One of the more interesting things that we're doing right now is integrating the principles of family-centered care into our program. The hospital has a long commitment to family-centered care. In the NICU and the ICC, family-centered care means that parents are able to be with their baby 24 hours a day and young siblings can come into the intensive care unit to see their new baby brother or sister. We've been collaborating with 11 other hospitals around the country around family-centered care. For us, one of the nice things that we've found is that a lot of our practices that we already have in place are family-centered care. It doesn't mean there isn't room to grow. Oftentimes the parents come into the unit and they don't feel like parents. They don't think of this new being as their baby. The baby is taken away from them, put in an isolette, and feels very removed. They wonder, "How do I then develop a relationship with my baby?"

In my own work, what I'm doing is try to help parents find ways that they can parent their baby. I work with the medical team to help foster the relationship between the parent and their baby.

**Participant:**

Could you speak a little bit about where the medical personnel is regarding attachment issues?

**Martha Schermer:**

When you say the medical professionals, I assume you are referring to the doctors. In the NICU and the Infant Care Center, I work with a group of 12 neonatologists. I think some of them are much more aware of the importance of attachment and parents spending time with their baby. There are other doctors that are much less aware of it. To say they don't care, I wouldn't go that far. They do care. But oftentimes the way it comes back to social work is "these parents haven't been here enough yet to visit. So social worker, go and find out why that is. They should be here more often." They don't say what the parents should be doing, but they do look at how much time parents are spending in the hospital.

**Susan Schultz:**

Is there anything in the protocol that involves all of the disciplines looking at the developmental needs of the baby, the developmental progression of the baby, and the relationship between the parents and the infant?



Jeanne Martin, Betsy Horton, Sue Benolken, and Ann Gearity

***Martha Schermer:***

There is a committee that looks at the developmental needs of the child. Nursing and occupational therapy are involved. We have a Parent Circle, which is a group for parents looking at child development and reading the cues of their infants from the premature perspective. With occupational therapy, we're looking at positioning, how the baby is held or positioned in the crib, and helping the baby learn some self-regulation. There's also a developmental care plan, which parents often write in partnership with professional staff. The care plan includes things that will help soothe the baby — what the baby likes and what the baby doesn't like, what you can do to help the baby calm down if the baby is irritable or fussy.

***Beverly Propes:***

In the team, is there ever an issue of culture or trying to understand the culture that this family comes from?

***Martha Schermer:***

Yes there is. Oftentimes it's looked to the social work staff to represent what might be different for the family in regards to their culture. When we talk about culture, it can mean so many different things, such as being an immigrant who has recently come to the United States and experiencing western medicine versus what they would have experienced for health care in their homeland. Oftentimes they will look to us to help interpret some of the cultural issues. Literally, we will use interpreters for families with foreign languages. Our use of interpreters for families from other countries has increased dramatically over the past years.

***Dorothy Liszka:***

I have a question about the services you provide for the infants with parents who do not visit or actively participate — what do you do for those infants, and who does it?

***Martha Schermer:***

I can give you an example. Recently we had a baby that, prior to the baby's birth, the mom chose to place the baby for adoption. Typically in our NICU, we don't have volunteers to come in to hold the babies because, more often than not, the babies are unstable. So in that situation, the nurses were holding the baby on a regular basis. Once the baby was stable enough, we did have a volunteer come into the NICU. Once the baby moved to the step-down unit, holding the baby more and spending more time with the baby was a priority, whether it be a volunteer or the nurse.

***Betsy Horton:***

I know we'd all love to hear more, but we need to move on to Beth Vossen and Gary Schwery from the Dakota County Challenging Behavior Consultation Program. Please tell us about your program.

***Gary Schwery:***

We are focusing on families with young children at the "Education and Support" end of the continuum. We also work with kids who are at risk or have developed emotional or behavioral problems by a preschool age. We're in the second year and are funded by a county-wide grant from the Children's Mental Health Collaborative for Dakota County. All of the 10 school districts can refer into our program. Primarily, over the last year and a half, referrals have come for kids who have been through screening for early childhood special education. Sometimes the children were not eligible for early childhood special education and yet there were a number of parent concerns, so they were referred right to me. It's meant to be an easily accessed, quick, convenient, in-home or home-based, or onsite at a child care setting.

The most exciting part is it's meant to be very easily, quickly accessed. I'm willing to come morning, noon, or late evening to be a consultant for both child care providers and parents in dealing with difficult behaviors.

***Beth Vossen:***

In 1998 we set up a task force with members of the Collaborative to look at what the issues were in terms of early childhood mental health. Where are the gaps? What did we need to do?

We did this previously in 1995, but nothing happened. It's amazing what happens when the LCTS dollars (the Local Collaborative Time Study) hit the table, because then we knew there were resources that we could access. The energy level went way up in terms of the commitment by the people who were on that committee. We had a large contingent of parents on that committee, and we looked at their issues. That was our primary mover — parents who said my child is getting kicked out of the third daycare in six months, parents who said our child is now 12 and I called the county when he was 2 and 4 and 8. We wanted to be able to address parents' concerns in a very easy way.

So we took our results to the Collaborative. We now have funding to serve about 70 children a year, which seems to be about our demand. Parents can call

any one of the partners in our Collaborative. We funnel all the referrals through Early Childhood Special Education so that the children get some type of a screening process to determine whether or not they might be eligible for those services. We don't even have a referral form. We really tried to cut the bureaucracy here. All it takes is a phone call or a fax to Gary with the assessment information or the screening information from Early Childhood Special Education, so a parent can get someone coming out to their home to help within a week. It's really exciting.

We're in the process of doing some longer-term follow-up, checking back with families six months after we have finished serving them. Gary sees them an average of six sessions, ranging from one or two to twelve sessions for some families. For those needing longer-term intervention, we refer on to other resources after that. It's meant to be an assessment and a short-term intervention service.

Another exciting part of it is our work with the Collaborative in establishing these services. We have an opportunity for some long-term funding. We also have an opportunity to look at this as part of a continuum of service. This service is in the prevention/early intervention stage, and it gives the opportunity to folks that are more focused on older kids and more expensive services to look at what we need on a broad base in Dakota County.

I should also tell you that the service is open to kids from birth on, but so far I think the youngest child we've served is two. We refer children less than 18 months to our public health nurses who do an excellent job with young families.

***Participant:***

Can you describe what kinds of things you might be doing when you work with families?

***Gary Schwery:***

First of all, I do a quick assessment of what is happening with the family. Each family has an individual culture, their own values, and their own ways of doing things. It may be influenced by their ethnic culture or their neighborhood or family of origin. But my first assessment is what's going on with that family group and also what's going on in their home. What kind of environmental factors are happening within the home or within the neighborhood that are influencing this little person? The assessment may include parenting factors, neighborhood factors, health factors, and developmental factors. I really want the parents to be in charge and the leaders. I'm always looking for confidence-building, skill training, and empowerment for what they would like to see happen. My favorite question is to walk in and say what do you want to do? Usually I get great answers from that, and I follow their lead.

Intervention can be a number of things. For families who are really interested in reading and doing a lot of work, I have a lot of psychoeducational material that's helpful to people. For the most part, it's fairly behavioral and fairly hands on, targeting certain kinds of troublesome behaviors and following those.

***Participant:***

Could you describe your interventions in the center?

***Gary Schwery:***

If a particular staff person is having difficulty with a child in a room, we'll focus especially on that. It may be just the dynamics between that staff and that little person. Several centers have done some staff training because that child was having consistent kinds of behavioral problems throughout the entire center. So we've done some staff and team work on developing a plan that everyone follows.

***Dorothy Liszka:***

Once you do the family assessment and you do a plan for intervention, do you use any other support? Do you use skilled counselors or in-home therapists or anybody to assist in that plan? My understanding is that you're short-term intervention.

***Gary Schwery:***

From four to ten sessions, with an average of about six for the first 75 families. If it's going to be longer term than that, we quickly figure out what other resources are available. Part of my own training is as a wrap-around team facilitator. So I look for those informal supports as well. It may be another family member or a neighbor sometimes. Most of the families we worked with don't have a good insurance plan that we can look to and say we'll hook you up and get you started. We have some luxury at the clinic I work at that, for folks who don't have insurance, we can provide a county contract for in-office work as a follow-up. I've also helped six families apply for Medical Assistance and get that ball rolling.

***Betsy Horton:***

Thank you very much, Beth and Gary. Next is Cindy Toppin from Ramsey County Early Head Start.

***Cindy Toppin:***

For those of you who are familiar with the Three to Five program of Head Start, which has been around for a long time, about five years ago the federal government started funding projects to serve pregnant women and families with children birth to three. Each community could present whatever model it wanted to. So around the country, Early Head Start is very, very different. Sometimes it's center-based, sometimes it's run by the schools, sometimes it's run by public health nursing. It can be really different depending on where it is.

In Ramsey County, what evolved was a collaboration between RAP Head Start, ECFE, and Lifetrack Resources (formerly St. Paul Rehabilitation Center).

The project is housed at Lifetrack and uses a home visiting model where the home visitors go out once a week. Weekly visits are mandated by the Head Start performance standards. The families are enrolled voluntarily. We were funded to



**Dorothy Liszka, Kathy Jefferson, and Betsy Horton**

serve 40 families. There can be any number of children in those families, but the program basically serves 40 families. The caseloads are mandated by the federal government and each home visitor can only have 10 to 12 families, which allows for quite an intense service model.

There is also a parent support and parent connection piece to it. We decided to do that through ECFE. Why reinvent the wheel? That's part of our philosophy of service integration in Ramsey County. If somebody else is already doing it, then let's try to connect with them. We work with the families all over Ramsey County and try and connect them to ECFE in their school district. If one class doesn't work, maybe we'll try another class. We have the flexibility and the funding in the program to do whatever it takes.

Our goals are around child development, health and nutrition, linking people with community resources, child care resources, and connecting families together. One of the reasons why it works (and we've only been doing this project for a year) is that it truly is a collaborative. We're sharing money and we're sharing decision-making. No one of the partners that I mentioned could make a unilateral decision to do anything. It takes three of us voting to really make any decision about governance or policy changes.

The other piece of why I think it's working is that we've chosen to hire B.A.-level home visitors. They can have a B.A. in child development, social work, or related field, but they also need to have some home visiting experience. We realized quickly that with the target population of families with multiple risk factors (not just the first 40 families that met the income eligibility), home visitors could quickly get out of their depth with some families. So we also have a collaboration with Ramsey County Public Health. One of the public health nurses comes on-site eight hours a week and reviews every single case with the home visitors, as well as doing team consultation. Similarly, a mental health consultant reviews all the cases on a monthly basis. Obviously, if the family's needs are more intensive or complex, we try to connect people with community resources.

One of the reasons I think it works is we're able to do some things that public health nurses and county social workers can't. If we need to give someone a ride to the food shelf, we do it. If they need transportation to a doctor appointment, we can do that. We have the flexibility to provide transportation. It's that kind of individual flexibility that I think is the true success of the program. It's very much family-centered. The family develops the goals. We don't say this is what your goals are; it's whatever the family wants to work on within the parameters of our guidelines.

The one downside that I personally see to the program would be the performance standards requirement that once the person is enrolled, they get a weekly home visit whether they need it or not, from the time a person is pregnant until their child transitions into the Head Start Three to Five program. Therefore, if a person continued to have babies, you could end up with years and years of service. You could argue that maybe some families need that, but maybe a family is doing well enough to be transitioned into an ECFE<sup>3</sup> program or some other less intensive service. That would make room to provide this more intensive wrap-around service to more families.

You have to also remember that this is a very new federal program. They're changing the requirements and trying to learn from the projects so that they can change the programs as we go along.

***Betsy Horton:***

Could you please explain more about ECFE?

***Cindy Toppin:***

When the regional office of Head Start looked at our proposal, they said "What is this ECFE thing and why aren't you offering your own parent classes? Why are you doing this collaborative thing? This doesn't make any sense to us at all." We almost were not funded because of that. We had to meet with them and explain what the system of ECFE was in Minnesota.

***Betsy Horton:***

Thank you very much, Cindy. Next is Sandy Hewitt.

***Sandy Hewitt:***

Thank you. I'm a psychologist in private practice. I work with a network of child psychologists that work in pediatric forensic psychology who interface with Child Protection, with judges, with attorneys, with police, with medical personnel, with a primary focus on child abuse and neglect issues. So I'm on the far end of your continuum.

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<sup>3</sup> Early Childhood Education (ECFE) is a program for all Minnesota families with children between the ages of birth to kindergarten enrollment. ECFE is based on the idea that the family provides a child's first and most important learning environment, and parents are a child's first and most significant teachers. ECFE works to strengthen families and enhance the ability of all parents to provide the best possible environment for the healthy growth and development of their children.

People in my position typically provide evaluations of children for termination of parental rights. More recently, with the education of the bench, I've been getting a number of requests for evaluation of attachment in cases of termination of parental rights. I also do consulting with a variety of people. Sometimes attorneys working with divorce need information about placement of a child or visitation schedules for children in high conflict divorces, especially very young kids. There's a whole variety of cross-issues of infant mental health, but primarily the bulk of the work I do is child abuse and neglect.

One of the questions you asked me to respond to is what is going really well in my work. Well, not a lot. It's a difficult area. I am most frequently struck with the absolute chasm that seems to exist between your discussion, Marti, about teaching parents to read their infants' cues and protecting infant mental health and, yet, if you move into child abuse and neglect, the system is the antithesis of infant mental health. You have multiple placements, real young children coming into placement for six weeks. They can't stay there even if they begin to have supportive relationships, so they're bounced to three and four other placements. It's very hard to stop the system. That's probably the most frustrating piece.

Other concerns I have besides multiple placements are the quality of in-home parenting services. Some are very good. Others don't have a background in attachment, so they're teaching behavioral strategies. If the court determines in the parent's case plan that they're to have these children back, they have to complete in-home treatment or attend a parenting class. So parents go to an ECFE class and learn about some management or somebody comes in to teach about how to manage your child better; but the quality of attachment between that parent and child is never addressed. I think that's a key piece that needs to be built in to the assessment issue on termination of parental rights or child abuse and neglect cases.

In the child abuse and neglect area, we often do assessments for prosecution. A lot of the work is in child sexual abuse with a special interest in 18- to 36-month-old kids because we document sexual abuse by how well children can talk. So the methods for assessment there are really based on the verbal level of children. That discriminates against young children; they are really disenfranchised. So I think another area where infant mental health can affect that system can be in doing assessments not just for prosecution but assessments for protection of the youngest children. Just as you were saying, you read the behaviors and teach parents to look at the behaviors of the young kids. NCAST<sup>4</sup> does that, attachment research does that. Transitioning some of that into assessment, where you're reading the behaviors between the parent and child and drawing conclusions with the child being an active participant in the quality of assessment that you do, is imperative.

Another concern is the lack of training or support that foster parents have. Some have an innate ability to create a secure attachment with children. I'm seeing one now where a child came in who was totally disregarding of people

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<sup>4</sup> NCAST: Nursing Child Assessment Satellite Training provides health professionals training in the use of scales that assess caregiver-child interaction.

and would growl in response to questions. She's been there about nine months and now is very fearful of the absence of her foster mom, so she's begun this wonderful work. I don't know that she (the foster mother) could really define attachment for you. She knows it and she knows how to do it, but I think there's a need for additional services for foster parents, especially if they're new to foster care and the child has an attachment disorder. Foster parents get a child with a specific kind of abuse background, and there are footsteps that are left from that abuse, things a child carries with them, and they'll act it out in new environments. Again, attention to the behavior in these very young children is a critical piece and part of the advocacy that we can do for infant mental health.

***Betsy Horton:***

In children, behavior is their language.

***Sandy Hewitt:***

Yes, exactly.

***Dorothy Liszka:***

I have a question. Regarding concurrent planning for required permanency in six months, have you been working on any of those cases? And do you have any impression about coming up with that kind of a permanency plan, particularly if you've worked with termination in that kind of a short period? Can you comment on that?

***Sandy Hewitt:***

As a child psychologist, I have not seen a lot of cases yet with concurrent planning because it takes time before a psychological status report is needed, and this is a relatively new structure. The biggest problem I see is that the timeline for case decision-making is postponed well beyond the one-year deadline. Maybe there was a problem with the parent challenging the adequacy or timeline of a case plan or the therapy/intervention services requested for the parent and child were not available. These problems in the case plan result in extensions and the child remains stuck in placement.

When you sit in a position where part of what you work with is pathology, you're going to see the worst cases. What I see happen in a couple of those that have come in with concurrent planning (and I have not had a lot of those yet because it takes awhile for the system to get to that point) is that often there is still some abatement in the additional planning because there may be some glitch in the way the parent followed the child protection plan or some services that weren't available. So they tend to get extended for longer periods of time. That's a major problem that I see.

***Susan Schultz:***

Sandy, in terms of your own caseload, do you balance assessment with treatment or are you doing 100% assessment?

**Sandy Hewitt:**

Right now, I'm probably doing about 80% evaluation and consultation and about 20% therapy. The reason I'm doing that is because if I'm teaching at all, I'm not available for regular, ongoing therapy. I think that's a disservice to kids, so I'm only carrying a couple of long-term cases — maybe about six cases.

**Susan Schultz:**

How do you sustain it? How do you do assessments without the gratification of seeing what happens?

**Sandy Hewitt:**

You know, I think about that. Maybe I have some form of psychopathology! Two things: One, I like assessment. I like the challenge. Two, the reward ratio is pretty small in this. You may do eight assessments and only get a couple where you think something happens. It's very important to me that there be some voice for these young children in that system. If part of your evaluation can provide that, it's very rewarding. So that sustains me. The other part is I have a wonderful network of friends. There are eight of us who do this work, and we meet together about once a month. We all complain. We gossip. We bring resources in. I think colleagues are the primary force.

**Participant:**

Can you speak to how much weight your recommendations have in the court decisions?

**Sandy Hewitt:**

I do evaluations of children from all over the state, and it depends on the education of the bench and who the players are. The bench is the hardest one to educate in this area, in some ways. So it's a whole team process. It's interesting to see who asks for the evaluations. The last two have come directly from the judge. The case is in and they file the case plan but there's still a major problem; and the judge, because they're educated, requested an evaluation of the attachment. In some cases, the primary attachment is not there and these are the responses from the child that indicate that. So then you can have a lot of power.

I don't do work for one parent or the other; I'll only do it under court order now. So in that sense, I try to use the system to weight the opinion. It depends on who the attorneys are.

**Participant:**

Are you advocating training judges?

**Sandy Hewitt:**

Oh yes! All of us should do that, wherever we can, both formally and informally. I really think that's an important area.

***Participant:***

What do you see as the treatment resources or lack of resources for young children who have been sexually abused?

***Sandy Hewitt:***

Well, if we're talking about infant mental health and very young children, play therapy is really for children who can talk and children who can play. So if you're 36 months and under, there are very few resources. Yet, we know that some of that very early interaction is part of what forms this underlying template for human relationships. How do we deal with trauma that happens with nonverbal kids? I know of a couple formats for doing that. I've been doing some of that lately. I'm absolutely intrigued with it, but there aren't a lot of resources for those very young kids. It's usually wait until they can play. I think we need to develop more resources for those very youngest children. Mental health centers and practitioners should be available to deal with children and their families because the younger the child, the more you have to work with both parent and child. I'm not aware, across the state, what those resources are like. I know that they're taxed here even in the metro area.

***George Realmuto:***

Sandra, obviously you're a leader in the field in Minnesota and nationwide. Some of the things you are saying today we've been saying for the past 15 years. Is the solution a legislative solution, a policy solution, or is it, case by case, informing the people who are making these decisions to make better decisions? At what level of the system do these changes need to occur?

***Sandy Hewitt:***

I think it involves all three of the things you mentioned. I think it's legislative; I think it's still case by case; I think it means intervention across systems. I've regressed in my field. I worked in student personnel, I worked with adolescents in treatment centers, and I've worked in schools and Head Start. Now I'm working with younger and younger kids. I'm speaking to the choir, but I have the feeling that the more intervention we do with these younger kids, looking at children who are in trouble, if you start looking at the attachment and the quality of those relationships, I think you get the biggest bang for the buck there. We're here because we believe that. How do you shift people's opinion? By facts, I think, but it also takes training to see that. When do you pick up on psychopathology? Who's eyes are watching these problems, and at what level are they able to report? So there are multiple levels to train the people who are looking for these problems. So I think it's multi-level and multi-systemic. I don't think there's one answer to that.

***Participant:***

Can you give me an estimate of the number of cases you had last year where you recommended parent termination of rights?

**Sandy Hewitt:**

I don't recommend that. That's a legal decision. What I do is talk about the strengths and weaknesses of the parent and the interaction of the child with them and reviewing records and looking at probability of change. How many of those did I have? Sometimes I work so fast I just don't look back and count, so I really am not aware.

**Cindy Toppin:**

If I could make one follow-up comment, there's some new data available from the Office of Evaluation and Research in Ramsey County which show that Minnesota ranks in the bottom 15 states in terms of its contributions to child welfare. We've hosted a couple of community forums, an interagency group, to try and get the word out. What we're trying to do is develop a child welfare legislative and county advocacy organization. In terms of what Ramsey County needs to do, there's a real severe budget crisis right now, but we're also looking at developing statewide legislative strategies around these issues. I think that it's criminal that we're in the bottom 15 states and we think we're wonderful in terms of supporting children's services. I think we really need to educate people about the need that's out there.

**Betsy Horton:**

Amen. Now, let's move on to Chris Hansen. Chris is with Early Childhood Special Education (ECSE).

**Chris Hansen:**

I work in the Carver County area for four school districts serving young children birth to age three. What are we doing really well? Certainly, we're finding a lot of young children and their families and doing good jobs of assessing and getting the children into programs. When they come out the other end and are ready to transition into preschool programs and Early Childhood Special Education programs, parents are, generally speaking, empowered and good advocates for their children, and they know a lot about their child's development.

I think one of the fun things that we've been doing in the past couple of years is collaborating with other agencies. Last year we had a couple of opportunities to do assessments together with public health nurses where, for example, we want to do a feeding observation, so our occupational therapist is there to look at the oral/motor aspect and sensory aspect of the evaluation. The public health nurses then do the NCAST and assess the interaction aspect. So it's nice to be able to work together.

Along with Early Childhood Family Education (ECFE), for the last several years we have purchased classroom slots for the children (qualifying for Special Education and Early Intervention) whose families also want them to attend early childhood family education. We attend the class for part of the time, whatever percentage of the time that the child needs us there, to support that placement and enrollment. We consult with ECFE teachers, so we're working together and those kids are included in the classroom.

We also have recognized that sometimes a mainstream ECFE classroom does not work all that well for some of our families, so we have just started some classes that run for short series — four to six weeks in the evenings — just for families with children that are in our early childhood special education program. The early childhood family education parent educator leads the parenting time of that class on topics relevant to parenting a child with special needs. The ECSE staff is there to help support and make sure the kids are successful during the playtime and the parent interaction part of the night. That has gone very well.

Another thing that's going well for us and that we're very thankful for is our system of central intake. We have a central point of referral and service coordination for all of our families. This makes our program much more accessible and available to families.

One of the nice things that's happened in the last couple of years is the availability of the Local Collaborative Time Study (LCTS) monies. We've been able to add a behavioral consultant on our team through an interagency position. It's wonderful because that person works year-round, not just during the school year, and is available to children from birth up through elementary school. So that's a great resource for us. Kids do not need to qualify for special education for access to the services of the behavioral consultant.

Using LCTS funding we've also been able to have an autism specialist who is available to kids from birth up through age 21 through a year-round interagency position. It's so nice that when we get her started with our young children (two years old, for example), she can move with them through the system when they leave our program.

One of the needs that I see is the gaps in services. When kids come in and we identify developmental concerns but they do not qualify or meet the criteria for early childhood special education, that is so frustrating. We always try to follow up in three months and recheck, or tell parents to call us if they have concerns. We arm them with materials and handouts and information. We refer them on to private therapies. But you're never quite sure. You feel like you're dropping the ball sometimes.

The needs that I see involve kids that don't qualify for our services. Sometimes we feel we're not able to address the needs of families that, for whatever reason, don't fit into the mainstream programs. Take Early Childhood Family Education, for example. Some families are at a different place in their lives and don't always fit into those classes. We're always working together with the ECFE people trying to find something that will work, but that can be frustrating. Also, we struggle to find the supports that will work for adolescent moms. They are a really unique population with unique needs.

***Betsy Horton:***

Any questions for Chris? If not, we will move along. Renee Torbenson is with Early Childhood Family Education at North Memorial.

**Renee Torbenson:**

It sounds like most of you know what ECFE is: Early Childhood Family Education. The work that I do at North Memorial is based on work that was started a long time ago by Joann O'Leary and Jolene Pearson at Abbott Northwestern Hospital. I provide classes for parents on the postpartum unit; classes that parents can attend after the birth of their baby to learn more about infant capabilities, the importance of attachment, that you can't spoil your baby by responding to their cries, and so on.

Several years ago infant development grants became available for Early Childhood Family Education programs to enhance their infant programming and Minneapolis decided that they wanted to expand that program to North Memorial and Hennepin County Medical Center. Because of that, we've been able to see lots of families much earlier than we've ever been able to see them before. ECFE has always been there to serve families from birth to five; but I have to say from having been in ECFE for a long time, we tended to see more families when their children turned two and started saying "no." We knew that if we could reach families earlier, we could support them sooner. That's been my experience at North Memorial.

We teach classes at the hospital five mornings a week. My co-teacher provides a neonatal intensive care support class. Families come to that class to learn those important pieces of information about attachment and infant cues. I can also go to the individual patient rooms to reach families that might not feel comfortable coming to a class or if it just doesn't fit into their schedule.

We tell them about ECFE and other parent and family support programs out in their community. We know that we can't make all the difference in the world in one half-hour class, so we tell them about other classes and make sure they know where there is one close to them in their community, give them the phone number, and tell them about the program.

One of the biggest challenges that we've faced has been the wide range of non-English speaking families that we see. I don't see as many at North Memorial as Hennepin County Medical Center does, but we've done quite a bit to try and meet that need. We have a Hmong bilingual professional aide to try and reach families. We have developed materials using photographs and illustrations that are used by the Hmong aide to show families some of those things visually with their language interpreter there. We do have many classes in our community for Somali, Hmong, and Spanish-speaking families, so we refer them there and hope that they can come and feel a sense of support with families of their own culture.

Probably one of the biggest things I've learned from doing this work is that face-to-face personal contact really does make a difference in getting people into our classes. I also collaborate with some of the childbirth programs in the community. Some of the childbirth educators have been very open, and I've come to their class on the last evening to help co-teach and talk more about the transition to parenting once that baby arrives, talking a little bit more about expectations and so on. Then I'm able to tell the families, since most of them deliver at North Memorial, that I will be there and I'd like them to come to the class. I watch for

their names and go and visit them when they are in the hospital. I'm also able to say that I teach the infant classes in your neighborhood and here's a class that you could attend.

In my early infant class, I'm an infant massage instructor and also teach that to families with babies up to about age six months. My entire class has been made up of people who I've met at the hospital. So I've found that it really makes a difference. In the past, we weren't able to serve families early like we do now, so I feel we're helping to provide early education and support. That's where we are on the continuum. When we come into situations which we feel need much more attention, then we can search out those resources.

Collaboration is really the key. You have to go where the babies are. That's what we learned in ECFE. You can't wait for them to finally get to you. So going to the hospital, going to the clinics and the child birth classes has been our key in reaching families earlier, which is so important.

***Betsy Horton:***

Questions? Thank you very much, Renee. Shall we move on? We come to Tom Anderson, who is from Minneapolis Way to Grow, Southwest Family Group.

***Tom Anderson:***

I work at Southwest Family Resources Way to Grow. We work with Early Childhood Family Education, the Minneapolis Visiting Nurses Association, and the Minneapolis Public Schools to get kids ready for school. It's very much a collaboration between a lot of different people. I've had a lot of contact with Early Childhood Special Education when necessary. Minneapolis Public Schools is very involved in helping us determine what makes a school-ready child, what some of the signs are, and how to work with them early. Our particular site has developed a focus of working with families early during the prenatal period.

I'm working with children ages zero to six. I also provide dad and baby classes and expectant fathers classes. I'm a parent educator for a Parenting Together project that focuses on fathers. I network with other men who are working with men in the city. What's going really well is that I see a lot of guys — soon-to-be dads and current dads — that really want to get attached to their kids and to play an active role. I feel really fortunate to get to work with those guys. They're out there and want to get involved. You hear a lot about attachment with the mom, and I know we're hearing more with dad, what to do, and how to do it.

It struck me when Marti Erickson was talking about looking at things in a broad sense that it's not just the parents that we need to work with around issues of attachment and infant mental health, it's the whole community. We had a focus group last week where we got feedback that we provide such a big range of activities in connection with others in the community, and families are really appreciative because that's drawing them closer to their children too.

Our program also provides home visiting. In home visits we have an opportunity to bring a parent educator, a nurse, or other coworkers who have specialized knowledge of resources in certain areas, such as housing, for example. We have access to a lot of people that provide services for families.

We also work with MELD. MELD is a nationwide program and is a long-term, two-year parent support group for parents with a variety of lifestyles, whether it be rainbow families, special needs, growing families, or new-time parents.

***Betsy Horton:***

As you're talking, I'm realizing that this program comes closest of anything I've heard to expanding its reach to the entire population. It sounds as though this is not just children at risk but supporting people who, even without the services, might do pretty well but now do very well with the services. There's always a tension, isn't there, between where you put your resources — where you can enhance functioning with a higher functioning group and where you can really lift the bottom.

***Tom Anderson:***

We now have more pressure to provide home visits to families. If you have a family that's pretty intact and doing well and possesses many skills, I have to go out as a family resource worker and try to design a program so that everyone sees some value in it. They want to be in as many houses as possible and provide the services right there in the home. That was one of the things I put down as a training idea: How to develop services that are pertinent for all levels of families in all areas.

***Participant:***

Are the families you serve all self-referred?

***Tom Anderson:***

No. We get referrals from ECFE, Metropolitan Visiting Nurses Association, and other Way to Grow sites. The majority of families are probably referred from other agencies.

***Betsy Horton:***

Now I'd like to turn to Terrie Rose, our last panelist.

***Terrie Rose:***

I'm Terrie Rose and I help coordinate the Irving B. Harris Training Center for Infant and Toddler Development at the University of Minnesota. I'm here today to talk about taking research and applying it to direct clinical or broader-based services. At the Harris Center, my colleagues and I are dedicated to the idea of taking research and best practice and making it applicable to what can happen in the world today.

The STEEP program<sup>5</sup> that Marti Erickson and Byron Egeland designed is our first really strong move towards that. That is going in a number of locations now, and

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<sup>5</sup> Project STEEP: Steps Toward Effective Enjoyable Parenting is a comprehensive and intensive preventive intervention program which has as one of its major goals the development of a good quality relationship between mother and baby.

I've had some involvement with that program working particularly with women who are substance-abusing or using chemicals during pregnancy or who are in environments in which there is a risk for that.

Our most recent initiative and the one that I'm most excited about is a collaborative venture of multiple early childhood organizations, including Fraser Child and Family Services, Reuben Lindh Family Services, Southside Family Nurturing Center, the Minnesota Children's Museum, Greater Minneapolis Daycare Association, and a number of university groups who, two years ago, got together around an idea rather than a funding stream. The idea was that we were all serving a lot of families in wonderful ways, but we were becoming more and more concerned about infants and toddlers and the impact of welfare to work on family systems that were already stressed by some basic management and daily living situations. The group came together around how do we want to see our vision for the future go forward. How would we create the best model that we could?

I'm glad to say that at the end of this month, we will have babies in this model. It's called BabySpace. The first location will be at the Little Earth Neighborhood Early Learning Center, which is located in the Phillips neighborhood. We have integrated the concept of early parenting support, starting with women during pregnancy, working to increase their access to medical resources, increase prenatal health care, and all of the things we know that support the healthy development of babies and young children.

Baby Space will offer full-time infant and toddler child care for those families who need a formalized child care situation. For a long time we've provided family support services and we've provided child support services, and now we are bringing those two things together so that the child, the parent, and the family can reach the developmental goals that they have in a continuous environment to allow them to progress forward. We will have continuity of care when our families start with us. We will work to keep them with us. Our children will stay with their primary provider that they start with in infancy. That provider will move with them into toddlerhood. It's really taking attachment to the most extreme degree that we can to provide that secure base so that each family can be successful in their future endeavors. So we invite you all to come and visit us.

As I said, this came together as an idea. We had the opportunity to go into the Little Earth Neighborhood Early Learning Center. That is a renovated Catholic school whose directive was to serve the families that reside at Little Earth, which is a housing development right across the street that is the only culturally specific housing development in the country, I believe. The people there are American Indian. What it did is it allowed us to say we will follow them and we will serve families that reside at Little Earth and in the surrounding Phillips neighborhood. They are coming to us. We had two walk in the door yesterday. The need for infant and toddler care is great. There are 20 new births alone in Little Earth, which is only a four- or five-block area. There are 100 children under the age of three residing there, and we want to know every single family that's there.

By being focused on one neighborhood, we all of a sudden will have 30 families that we work with that have a whole different model in mind of what support for their family is all about. Neighbors will be a part of this momentum of

building families and strengthening connections. They will know each other. Reuben Lindh Family Services is also providing child care in the same building, so we really hope that, within a small area, we can help rebuild community that has been somewhat fragmented because of a lot of social issues that converge in that neighborhood.

***Participant:***

How do families pay for these services?

***Terrie Rose:***

We are operating under the Hennepin County daycare reimbursement system. For families that, for some reason, are not eligible, we have scholarship money available.

***Betsy Horton:***

It all comes down to funding, doesn't it?

***Terrie Rose:***

In this case, that was what was unique about this collaborative. We believed we had the right idea and we went out and sold that idea. So we have state support, we have foundation support, and we have individual contributions.

Our top three staff are leaders in the American Indian community that have had years of child care experience and came to us from a variety of places. They provide a wonderful wealth of leadership for us as we move into the community. We are currently hiring teachers and are looking at a way of developing training models for people who are looking at increasing their knowledge and understanding of working within infant and toddler child care and resources.

***Betsy Horton:***

These are a wonderful wealth of programs that you've heard about here. I hope that they've provided good ideas for you to take back home with you and to think further about how these fit into the continuum of services.

## Panel 2 Discussion

### Moderator

Christopher Watson, Coordinator, Minnesota Infant Mental Health Project

### Panelists

Doris Bailey, Infant Mental Health Specialist

Lola Jahnke, Public Health Social Worker, Minnesota Department of Health, Children with Special Health Needs Statewide Coordinator for Follow-Along Program

Joan Mick, Behavior Specialist, Proactive Intervention Program, Anoka County

Terrie Rose, Coordinator, Irving B. Harris Training Center for Infant and Toddler Development at the Institute of Child Development, University of Minnesota

Veronica Schulz, Hennepin County Children and Family Services, Children's Mental Health Collaborative

Carol Siegel, Clinical Psychologist and Clinical Director of the Washburn Child Guidance, and Clinical Supervisor for the Outreach Consultation Program

Kristin Wheeler, Anoka County Community Support Program and Central Center for Family Resources

### *Christopher Watson:*

We're going to do this panel a little differently. I'm going to pose some questions. I'd like this to be more of a conversation between the panelists and other Symposium participants as well. The first question I'd like to ask is what interesting things have you learned in your work that are pertinent to our mission of constructing a framework for infant mental health services? So thinking more systematically, what is it in your program and your services that would lend itself as a lesson or something to be thought of in constructing a statewide framework?

### *Kristen Wheeler:*

In Anoka County probably 10 years ago, the Children's Mental Health Subcommittee of the Anoka Area Interagency Early Intervention Committee started looking at the issue of children's mental health and gaps in services. Out of the work that they did, the Community Support Program came to be. The program itself was designed to support children and families that had concerns in any area of social, emotional, mental health, or behavior. We could cross any line, serve any child, any family, in any setting. We provide home visiting and we also support child care programs.

Starting in 1994, that same group realized that that service only went so far. What was happening in our county was that we had children that were being kicked out of child care centers over and over again for challenging behaviors — behaviors that were not allowing them to be successful in child care. As has been reiterated all day long, when they're infants and toddlers, nobody looks at their behavior and sees it as an issue or problem; it's when they can't stay in child care

successfully that suddenly everybody starts talking about it. That's how what was originally called the BATS<sup>6</sup> project started and is now the Proactive Intervention Program.

One of the unique things that we found to be a great service model was that this was a group of people that came together around an idea and went out and found the money. The original one (the Community Support Program) is funded through county mental health dollars that are contracted to a private mental health agency for this service that we're providing. The BATS project searched long and hard and we got a start-up grant from Part B 619 funding from Early Childhood Special Education at the Minnesota Department of Children, Families, and Learning. It ultimately landed with the Children and Family Collaborative and has LCTS dollars. In that model, one of the things we found (and I've heard it said time and time again) is that when you provide that face-to-face contact with people, the relationship piece is so incredible. With the Proactive Intervention Program, it takes it up another notch. What we're actually providing for people who have children with behavior problems is the services of a proactive behavioral specialist for the kids who would not be successful.

It's not only the relationship between the behavior specialist and the child, but then also being able to come to the table with the staff and do hands-on mini-trainings (that we don't really call trainings because sometimes that intimidates people). You teach them about how it is to be with this child. Then you talk with the parents and find out more things about the parents and families as a whole. It's the relationships that you build with all of those different people.

We've learned that it's really about relationships and getting in early before the child care staff are ready to kick the child out. We need to get with parents early, when they first start having concerns. The Community Support Program has broad strokes. We don't have any criteria for eligibility. Families can self-refer and we get referrals through all different sources. We link parents up to other resources. We are considered one step short of therapeutic programming. If it's also necessary in child care, we can do general consulting. But if the child really needs another level of service, the community invented another program to take that up another notch. It's really due to the dedicated work of lots and lots of people. We've laughed about the fact that there is now a core group of people that could probably write any grant out there because you have to find money.

We think it's a great service model because our collaborative partners are literally everyone in the county. We have collaborative partners in every single school district in early childhood special education, early childhood family education, and with the Interagency Early Intervention Committees. Because of the work that we're doing now, we're also getting referrals directly from pediatricians in our county. Our family child care licensing division staff carry around brochures.

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<sup>6</sup> BATS: Behavioral Assessment Teams. BATs are Technical Assistance teams of early education providers who provide technical assistance to educators and families on ways to proactively and positively assess and prevent child challenging behavior. The establishment and training of these teams is provided through the Minnesota Behavior Project, a federally funded project through the U.S. Department of Education to the University of Minnesota. Mary McEvoy and Joe Reichle, Project Directors. Additional information may be found at <http://ici2.umn.edu/multistate>.

When they're doing home visiting, they're handing out flyers. So it's really getting buy-in from all the people who are seeing the families of young children and people who work with them. I always think of that old commercial of "you tell two friends and they tell two friends and so on." Anoka County tackled that and has really put it out there. We collaborate with everything from Healthy Start on up. We're trying to get in before there's a crisis.

***Carol Siegel:***

One of the things that I'm appreciating is how much Hennepin County underestimated the time it takes to provide the kind of service that we do. Our program is a capitated program, so it was funded for a certain number of kids. We see them in the Center twice a week and have a home visit once a week. Parents with severe mental health needs and lots of attachment issues were calling us five times a week for an hour at a time or longer. If they were allowed to, they would call three or four times a day if a therapist was available.

What we've been able to do is shift the focus. We have two home visits a week, one center visit, and in some cases can bill for phone calls as well. It's not so much about recouping moneys for the program but to give a more realistic sense of the true number of hours that it takes to make real change. In some cases, we have documented 15 hours a week for particular families. Nobody gets paid to do that kind of work, but if we're really thinking about efficacy and about what really makes change, and if we're going to design programs, it has to be based on real time. And it has to be able to follow families instead of just being a model.

***Lola Jahnke:***

One of the things that makes a successful model is being flexible enough that it allows diversity with our local partners. There are lots and lots of resources up here in the Twin Cities, but when you get out to outstate areas, the model that we develop here is probably not going to work. So a framework that allows for lots of flexibility in terms of implementation will bring about a more successful program.

***Veronica Schulz:***

I found a couple things interesting in developing the Children's Mental Health Collaborative. One of the biggest liabilities (and a big strength as well) that we have in Minnesota is that we have developed a lot of very good programs. We often think of ourselves as advanced or number one in the country in different areas. That limits us in looking at what other people in our state or other states have developed. There have been a lot of really successful things developed outside of here. Not everything successful has to be grown here. We can look and learn from other places.

The second thing I've learned, and it sounds a little bit like apple pie and motherhood, but it is very important to have a clear vision and to keep revisiting that vision. The difficult part is the farther your vision is from the current reality,

the more tension there's going to be. People will seek to try to resolve that tension by either moving the current reality towards the vision, if they can; but if they're not successful, try to move the vision towards the current reality and water things down. So trying to keep successes in the system, you keep that tension in that system. To move the current reality forward is important, but it is a difficult thing to manage once you get enough people that can see that what's happening now is not acceptable. They want to resolve that tension.

The third thing that I found very interesting is taking a holistic or wrap-around approach, serving the whole family and looking at meeting their basic needs as well as their child's mental health needs, so that they can parent and do the things that we all want for our own families and children. It makes sense to parents and community members and taxpayers taking that approach. That approach is very difficult for staff and people within organizations to understand because they overlay the current system and try to figure out how, in my current box, can I do that? I can't. I can only do what I've been assigned to do. I'm overwhelmed with what I've been assigned to do. I don't have permission from my superiors or my administration or my funding source or whatever to work outside of that box. I think that's been difficult. It's very easy to explain a holistic wrap-around approach to a community member or a family; it's very difficult for staff to try to think how they would operate in that approach.

***Participant:***

Do you think that's because we've gotten so specialized, like early this morning we were talking about people on the therapy track versus the education track versus the child care track?

***Veronica Schulz:***

Probably. I have a bias that we need some of both. We need to have specialists but we also need to try and work in a more generalist approach. I see that pendulum shifting. Now you hear a lot of people saying things that, to me, sound like a movement back to old-fashioned social work. So I think that pendulum is shifting back, but I don't think we can lose some of the specialized training and specialists that we have because some children need that and weren't well served in a generalist approach either.

***Joan Mick:***

All morning we heard "collaboration, collaboration, collaboration," and that's really what that is, all of us from a unique or specialized perspective informing and instructing each other and working together for best practice.

***Christopher Watson:***

I'd like to go to one of the questions that I get asked a lot when I go outside of the state of Minnesota. I think it's because other people are trying to figure out

how to address this issue, and that is “ how do you gauge unmet needs of the population you serve or don’t serve?” I wonder if any of you have struggled with that in terms of trying to determine exactly what the need for services is and how you go about structuring a response to that? With the youngest of the children in our care, it’s perhaps the hardest to demonstrate their needs versus the ones that are visible to the community, having problems in child care or school.

***Kristen Wheeler:***

We found it hard in going for funding for our particular programs because we all know it’s there, but it’s not easy to get anecdotal information to be able to document the need. In our particular case, we’re looking to fund a program where we’re saying these kids are getting kicked out of child care. Well, parents don’t volunteer that information, “ Will you take my child? They’re a behavior problem.” So it’s been difficult. Or, the fact that we’re trying to take kids that don’t qualify for special education services because we’re trying to serve them before they qualify. How do you find those kids and how do you track them to be able to say this child has been just a little off?

We have utilized numbers in Anoka from the screening processes in the Birth to Three programs. But even families that went through the preschool screening at our family care clinics weren’t talking to the screeners about problems. We all know it’s there. We bring together family child care providers and center-based providers, and they tell us it’s there. But it’s hard to come up with hard data.

There is a need to educate people that have the money to share. How do you explain the therapeutic models that some of these programs are based on — that make a huge difference. So much of it is not concrete — it’s more anecdotal. I know we’ve struggled with that. What words do you use? What terms do you talk in? Do you show decrease in placement? What do you track?

***George Realmuto:***

This issue that was brought up about source of referral: How helpful would it be to have some kind of mental health screening for children as they enter elementary school or secondary?

***Panelist:***

It’s too late.

***George Realmuto:***

What kind of mental health screening is available and is done by pediatricians? Why does the federal government say there’s a program called EPSDT<sup>7</sup> that somehow exists everywhere except Minnesota?

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<sup>7</sup> EPSDT: Child and Teen Checkups (C&TC) is the name for Minnesota’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. C&TC is a comprehensive child health program provided to children and teens from newborn through the age of 20 who are enrolled in Medical Assistance or MinnesotaCare.

***Dorothy Liszka:***

I think he has a good point. It exists. It's well funded. We're all doing EPSDT child routine screenings, but it doesn't really have a wide base for mental health screenings. Now, that isn't something that would be that difficult to include if we had some kind of a profile or guidance on how we would do that screening. I think it's an excellent idea. I think it can be built in because there's a lot of money in that program. We're getting about 90–95% federal money through that program, so I think that's an avenue to say where can we fit that?

***Jim Huber:***

Traditionally with EPSDT, the problem in Minnesota has been because we have such a benefit-rich Medicaid program, we've not wanted to open up some of the other aspects of EPSDT because along with that comes other kinds of strings and responsibilities from the federal government. However, I think the Department of Human Services is getting more open to exploring recommendations, particularly if they come out of this group. That's really the reason EPSDT is not used in Minnesota, because of our benefit-rich Medicaid program.

***Dorothy Liszka:***

And no one's ever said that this is an area where you could use it. Nobody has advocated for mental health screening.

***Jim Huber:***

Right. If that comes out of our meeting today, it may help carry it along. We'd certainly be willing to take that along.

***Dorothy Liszka:***

I live in rural Minnesota and half the towns I work in are in rural Minnesota. We have a very high rate of employment; two-parent families working. So what's happening? The mom takes off and delivers. Within two months or three months, she's back at work and the child is in some kind of licensed care, whether it's a center or family care. We license those homes. But it's part of that licensing problem. Do we do anything in terms of looking at the mental health of children in those homes? Do we even think about it? Do we rate it? Is there any kind of a screening process we could use to evaluate children's ability to form healthy attachments within that home? There are children in those homes 8 to 10 hours a day.

***Kristin Wheeler:***

And to piggyback on that, it's also an issue of training for the staff that are providing care. A licensed family child care provider is required to take six hours of training a year. There's no guarantee that any of those six hours have anything to do with child growth and development, infant attachment, relationship-building. They could take six hours in fun art projects. It's a voluntary system. They just took a bill before the legislature and got the number of training hours for staff in a licensed child care facility cut down.

There's a crisis in the child care community as well. First of all, we have more kids in care than we have staff to provide for, whether they're licensed family child care providers or center-based staff. Then, the qualifications that they're bringing are dismal. The pay they're receiving is equally dismal. So why not go flip burgers and get paid the same dollars, or more?

***Carol Siegel:***

Another issue is that there is copious literature that talks about depressed parents and the effects on children. Anyone that goes into these kinds of child care centers sees the number of depressed child care workers.

***Kristen Wheeler:***

Or stressed. When we were talking before about employers who want their families to be ready to come back to work, that also means that we need to get employers to look at child care settings that their employees are using and helping to support that. It's a broad-scoped system that needs to be addressed in that case.

Also, we found that with the mental health screenings that are available, again it's all voluntary. Anoka is fortunate enough to have Healthy Start<sup>8</sup>, which does screening in all the pediatric clinics for families that are at risk. They screen for risk factors, including parental age and other support systems that might put a family at risk before they even have that baby. But again, that's voluntary and family participation afterwards is voluntary.

***Veronica Schulz:***

Screening would be an excellent way to identify an unmet need, but you can't just screen; you have to have something available afterwards. The sheer lack of programming or service options that are available keeps people from doing screenings.

***Elaine Nelson:***

We have no good tools for screening. That's one of the most difficult things because there's no really good tool — birth to three, three to five — with a social-emotional component. There again, a parent is meeting a stranger for a half hour. They're not going to pour out their heart, nor should they. That's not the appropriate place for that to happen.

Problems are in the eyes of the beholder. We might think somebody has a mental health issue, but if it's not a problem for the family or child care, then it's not an issue and it's not a problem. That's one of our most difficult things is everybody says screening, and we've got those lists of 15 risk factors but there's no magic — if a parent meets three of those, five of those, one of them. So I think when we talk about screening, that sounds well and good, but we need to

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<sup>8</sup> Healthy Start: The Healthy Start Initiative is a national five-year demonstration program which utilizes a community-driven systems development approach to reduce infant mortality and improve the health and well-being of women, infants, children, and families.

have some help in how or what because we're not all trained in attachment. That's a real critical piece.

***Jim Huber:***

I'd like to see us shift our focus just a little bit. We have to look at the fact that, from a legislative perspective, legislators seem to believe that this kind of early intervention in families is intrusive. I think we have to change how we present early childhood screening so that we can create a better climate for legislatively directed and developed programming that allows us to get at this earlier and to say while it may be intrusive on the family from the Christian family perspective, it may still be the best thing from a public health perspective regarding that child. We haven't done a very good job of that at the legislature. I think that's the crux of our issue. We know there are programs and we can develop screening tools, but we can't get at the people that we need to get at because of that intrusion factor.

***Sue Benolken:***

My question would be we still view screening as a one-time deal, too, in terms of an infant mental health context rather than in the context of a relationship. When you make a connection in a real way with a family, it's much easier to move them into other services if they want and they're more available for that kind of opportunity instead of this quick one-shot screening mentality that we have when we think about screening. I don't know the answer to that. It's a change in our system.

***Carol Siegel:***

When you identify that parents have mental health needs, where do marginalized parents go for mental health services? When you were talking about unmet needs, we have found that we don't have a way to refer parents to any service that is continuous. If we're using a relationship-based model, it would be a place where a parent would be seen in a timely fashion by the same person repeatedly.

***Doris Bailey:***

In Michigan, we've had referrals from a hospital social worker when she would see a mother who's been taking medication for depression. People would be referred right to the program and immediately get a person who would be their worker on an ongoing weekly basis. Also, there would be referrals from people like public health nurses, people in school systems that have ECSE kinds of early intervention programs.

They would refer to the infant mental health programs, and then we would contact the parent and tell them this is voluntary if you want to have someone come out and talk to you about it. They don't have to say yes forever the first time; they're just getting a brochure and talking to you. So they'll let you come and talk about it. Sometimes people would say no. Other times, people get one idea in their mind and think this is a program for teenage parents, and so those were the only referrals we would get.

***Jill Weiss:***

One frustration I have is I think the program ideas are all wonderful, but I still have the feeling that we're going to be missing the families with the most severe problems. Some of it is tied to the child protection issue, that people are afraid to seek services because of child protection issues or because if child protection becomes involved, it's not often in a proactive manner. The most stressed families with the most stressed children are not always the ones that are going to participate in these services, no matter what the services look like. How do you reach some of those families who may have the most chronic and stressful needs, given the fact that some will not seek out services initially?

***Anne Gearity:***

I'd like the panel to speak again to the training issues — not just training families but training staff. My experience has been that many of the children that I'm seeing in preschool and school age-based programs are probably not going to have the best experience with their families that I would wish. At some point, I have to see myself as an attachment partner in a broader sense. I have to see myself and all of us as supplementing that experience. How do we train line staff to think of themselves as not only delivering tangible and mechanistic services but also relationship services? Many of the children that we're seeing are going to have to get a sense that the larger community offers them a possibility of relatedness that may be different than their family experience. How do we address that as a training issue? That seems to me the essence of the culture of infant mental health, that we see attachment as both a primary experience but also as the community responsibility and responsiveness.

***Lola Jahnke:***

That's an issue that I hear from my public health partners when I provide technical consultation with steering committees around the Follow-Along Program<sup>9</sup>. I hear of their concern about the children that we serve who are birth to three and those at risk and the training they would like to have in terms of identifying those kids. The tool we use kind of snips at infant mental health issues. We use an ASQ (*Ages and Stages Questionnaire*). They would really like to see that expanded so that they could go back and identify the kids but then have the training to know what to do.

***Anne Gearity:***

Where I feel like we get stuck is we keep looking for the screening models that say yes, there is a problem when probably 90% of the time your staff's instincts are good.

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<sup>9</sup> Follow-Along Program: The Follow-Along Program is an interagency effort to improve the identification of children who may experience health or developmental problems as a result of medical or environmental risks. The Follow-Along Program also assists in data collection and service delivery to children up to four years of age.

**Lola Jahnke:**

But they need the training to give them the context.

**Anne Gearity:**

How do we empower staff and train them to use themselves relationally? I think we're too focused on proving on a checklist that we've got something. Meanwhile, the children are objectified.

**Lola Jahnke:**

And the checklist doesn't answer all the questions.

**Anne Gearity:**

It never will.

**George Realmuto:**

There was a comment raised by a gentleman down at the end there. The line staff are saying I know who these kids are and I can identify them. We could use a measure, use a checklist, but one of the problems then is the services are not well funded enough to go about doing that kind of screening.

The other problem is that the legislators don't want this to happen. Is this an issue of stigma related to mental health? I can ask you if your child is blind or deaf or can't talk or can't walk, but I can't ask you if your child is disturbed, at least according to the legislators.

**Carol Siegel:**

But people are in the homes. We have lots of programs where people go into the homes. I think Anne's point is really towards what does the service look like that's in the home?

**Kristen Wheeler:**

When we talk about training, there's also the need to educate legislatively. Just take a look at some of the remarks that were made about who can provide child care, trained or untrained? Why can't they get the neighbor next door to watch their kids?

**Another Panelist:**

Or the neighbor next door says it's so easy, I'm just going to go down the street to the child care and get a job there because I can watch kids all day. They don't realize they have to give of themselves in order to be successful in child care and be that person to that child for eight or ten or twelve hours a day, that will love them unconditionally no matter what.

**Kristen Wheeler:**

I think it goes back to the education of the entire population — we need to do a huge marketing campaign with the general population about what are the key things that kids should be getting when they're in a child care program? School

readiness is not about knowing their ABCs. We've known that for years, but if you ask the general population, they're going to tell you that the reason their child is in child care is to learn their ABCs so they can go to kindergarten and learn how to write their name and be successful. So we've failed in the marketing to the general population of all the research that's been done. They're not seeing the connection. They're not understanding the connection between the brain research and what that means. That affects the child care system.

Even the staff coming out of four-year institutions with early childhood degrees — look at the number of classes on how to do art and science versus how many classes did they have in development and attachment and relationship. They had one social-emotional class. I went to college when dinosaurs were still on the planet, just ask my children, and I had one social and emotional relationship class. I had all these classes on how to do all of these other things, and I had one basic behavior management class. Now we have a few more things available. But again, when we're talking about universality, there's not a universal best practice model for training teachers. We're in the process of developing it, but some of those things still haven't come to bear. You get teachers fresh with their degrees who believe they'll just say "Children, it's time to clean up" and they're all going to clean up. That's what I deal with all day every day. Our staff are in that mode of "I'm the teacher and I'm in charge."

***Joan Mick:***

We keep talking about at-risk children. Really, aren't all of our infants and toddlers at risk right now in a culture that does not support child care, professional staff, mental health agencies — does not support young parents to be home with their children? Maybe what can come out of our Symposium, for our legislature and everyone else is the awareness that our youngest children are at risk right now, all of them. It's not based on socioeconomic only. I loved the comment about we don't want to talk about our disturbed children because disturbed children are formed by bad families. That's our belief system in Minnesota. Look at the statistics we're getting right now about racism. That's a crisis. We're in a crisis that we have to face as professionals who love small children.

***Terrie Rose:***

I was hoping to focus for a minute directly on what we can do in terms of training because I do think that there are things that we can do. The last part of the name of the Harris Center is Training Center for Infant and Toddler Development. So besides being out there doing seminars on brain research or attachment, we've taken this really seriously. We're working with Barb Palmer at the Minnesota Department of Health in the home visiting program and Betty Cooke in ECFE at the Department of Children, Families, and Learning. We're developing a statewide traineeship program for 8-10 people that are in the position of being able to train other people, either in their area of the state or in their organizations, that we'll take through a two-year mentorship program.

The idea is let's boost the people that are already out there doing it so that they understand relationship-based work, so that they have the research information they need about brain development and child development. We can support

them and nurture them personally and professionally so that they're out there able to work with the folks that need to be trained within child care. Then we can broaden our base. We hope to have the first class begin in September as a two-year project and then look at doing another round of training. There are things that we can do immediately.

In addition, I provide consultation with facilitators who are providing direct service. I see that always as a parallel process. I try to set up for them what I hope they will set up for the families with whom they work. I do that not as a clinical psychologist doing supervision, but as a facilitator who believes in inspiring change in people. So for Mother's Day, I brought potted flower plants to all of my facilitators because that's what they're doing: they're mothering those mothers or those families. That's what I hope they will do for those families.

We have multiple opportunities to train in our everyday work as well as in our structure. This is an area that needs lots of training and lots of support. We have to realize that we need to make serious contributions in this area. We need to allow the time and funding for supervision and consultation. We need to recognize that we all have a responsibility to encourage those others that are working in the field.

***Susan Schultz:***

Are there ongoing programs that have home visitors who are bachelor-level paraprofessionals versus more clinically trained staff? I'm interested in hearing from the panel what your experiences are and have you found ways to provide consultation to those who don't have a base of clinical training?

***Terrie Rose:***

What we know from the research is that they do different things. Paraprofessionals do different things in a home visit than a masters or Ph.D.-level clinical psychologist will do. The value of those things will weigh out for that family. I work mostly with paraprofessionals and I do see that parallel process — what I do with them and what they do with the families. The way in which I support their learning and growth is really the critical piece that helps them go in and do what they're doing. They just do it differently.

***Susan Schultz:***

One of the advantages of clinical training is to have some access to the self in the process. With the paraprofessional population, do you find a way to enter into that part of intervention work? By the parallel process, you are doing it without making it a necessarily conscious thing. Have you found that at times you are making that more conscious?

***Terrie Rose:***

Yes. It's when they say my father drank all through my childhood. I had a facilitator just tell me this. She said he was an alcoholic and unavailable. He was not able to make planning decisions. It comes, and it comes in the same way it does in the therapeutic process.

***Carol Siegel:***

I have both masters and Ph.D.-level clinicians go into the home as well as bachelors level. Both require an enormous amount of time for what some people call reflective supervision, time to be able to discuss how they felt and where their interventions come from. For someone with more training, you're hoping that they can catch their process as they're about to do something. With those with less training, you can dissect it later but they can't necessarily catch it on the way. Both of them take a tremendous amount of time.

***Dorothy Liszka:***

I want to add what you said about some of the good things that are going on in training. I don't often give a lot of credit to the Department of Human Services, but today I will. They have excellent child welfare training that they're doing now for county social workers. A lot of agencies like ours that have public health nurses and home visitors are now able to also tie into that kind of core training. I think that's an excellent opportunity to enhance skills. I agree that a lot of the workers know some of this and practice it. Sometimes they need to be mindful of new techniques, etc. I think that the child welfare training they are doing is an excellent method that's already in existence sponsored through the University of Minnesota. I think it's good to continue that kind of a training system.

***Jill Weiss:***

My experience at Wilder when I provided supervision for people doing in-home therapy and day care consultation wasn't so much the qualifications of the person as it was their ability to bring back information. When people are good observers and are able to bring back information independent of their experience, I felt we were able to talk and problem-solve and share information. What made me very nervous was when people felt like they had a lot of expertise but weren't able to bring back enough information for us to collaborate or problem-solve. The ability of people to be open and share information, observe, and bring back that information to me was more crucial than anything else.

***Tom Anderson:***

As a bachelor-level paraprofessional who goes into a home and has to refer back to the professionals for answers, often there are times where I say, okay, I just have to go in and observe and see what's going on and make sure that I don't go too far with it. I get my own insights from my experience and try to think of one way to respond, and maybe that's too far or an area I'm not supposed to be in. I have an example. A father called me and said he wasn't very attached to his son. He said, "I don't feel like I love this kid." The baby's three or four months old now. The father was really concerned. I thought the first step is he's concerned about it. I went to the house and we talked for a little bit. I wasn't quite sure what to do but knew I could come back. He asked me before I left what he was supposed to do. I said how about if for the next week until I come back, just watch your baby's eyes. Just look in his eyes and see what you see. When I come back, you can tell me what you saw. The week made a huge difference. I thought my lack of experience was either going to be therapeutic or not.

**Carol Siegel:**

You've started me thinking about the important aspects of working in this area. One of them is the ability to engage a client. Though it may be facilitated by education, it may not be. There's something about who that person is as a person as well. If we're talking about relationally impaired parents, which is our population, that's all the work. The work is will they call you back? Can you go again? If you've got more training, then you have a better shot at it, but if you've got the personality that engages, then...it's a hard call.

**Terri Helland:**

A profession that's not well represented here is the public health nurses and yet I hear them being applauded over and over again, especially in the panel discussions and how many of the different disciplines are depending on them. With their expertise, I think they're really unsung heroes. They are trained to go into homes and look at all aspects of health.

The second thing I want to say is that we're missing a piece here. Attachment begins prenatally. We have a system in Minnesota called Minnesota Prenatal Assessment. In our county, we're having physicians fill that out on all prenatal women. I don't care if they're low income, high income. I want to see that risk assessment. Physicians are doing a better job of looking at the socioeconomic part of risk factors. When we get involved prenatally, we're doing that relationship-building which is so important. If you can start there, you've done a lot of work that you don't have to start at age three. I think we need to look at public health as being a model of prevention. How have they done that? Where are the public health nurses that are doing that and how are they doing it? The problem is they're not adequately funded to do the job, and there isn't enough of them out there.

What I see, too, is when we make referrals for ECSE or we see children who are at risk for development delays, if the delay is not there, the services aren't being provided. Still, in that time span somebody needs to stay involved in providing education and support with the mother and the father and the child. We don't have a lot of support for what public health nurses are doing. We have county commissioners who say, "What do you mean we have parents who don't know how to parent their child? That can't be, not in this county." It's a difficult sell, but we need to really draw on the expertise of public health nurses. Some of the county agencies are doing universal screening at birth. They're at the hospitals. They're offering the visits. I guess I disagree with the idea that this is being intrusive because it's a voluntary service. They can refuse it. In Brown County we have a 97% acceptance rate, so we're not looking just at the children who have health problems. The families are accepting this because of the cultural risks they're up against. As parents, they're seeing that this is a job I'm not able to do myself. I need some support. So they're real receptive to that.

From the universal screening, we have an at-risk screening that we look at. We go in and do the assessment and follow-up is offered. I would say 90% of those families agree and have us come back. I think public health nurses are good at utilizing the resources within the community, but we need more services that start at birth. They're just not there.

***Jill Weiss:***

It would be interesting to look at the 10% of families that don't come back. Why don't they want such a nonthreatening service?

***Karen Lindberg:***

Being a public health nurse, I'd like to piggyback on what Terrie was saying. I think back to the Round Table<sup>10</sup> when Kathryn Barnard made her last statement. It was "Infants can't wait." I've been in home visiting for 20 years. For the first five years of those, we were only getting referrals after babies were born. Starting in 1985, we started doing prenatal outreach. Now, in Dakota County our highest priority is the prenatal clients. We see them as early as possible in the pregnancy and see them through the first year. I've also learned that when we were teaching parents after they came out of the hospital, they were very skeptical to take our information because it wasn't relationship-based yet. Whereas, prenatally, they are so ready to have a relationship with somebody who cares about this new experience that they're dealing with, we can teach a whole variety of things prenatally, including early brain development and how to read your infant's cues so that by the time the baby is there, we can really work on relationship issues more effectively because it's relationship-based.

***Kathy Jefferson:***

We were talking about when staff or child protection workers go out and work in the home. It really relates to what Terrie just said. We really have to model what we want. It's a philosophy which says we value and will create a safe place for staff to come back and share. It's very hard with bureaucracies to do that, but it's not impossible. That means we have to do what we're asking other folks to do, which is risky, which is talking about trust, growth, and skill development. We have to be willing to do that as organizations and agencies. There was a county social service director who said we're not in the business of relationships. When you have that kind of philosophy, it raises hell with staff and I'm sure with families. So education has got to go all the way around. We, ourselves, have to be ready to go out there and walk the walk. When you look at education, we have to include ourselves and our colleagues in that equation.

***Dorothy Liszka:***

I'd like to follow up on the discussion about the qualifications of the people going into the home and to piggyback on another comment. We have a family home visitor program in Stearns County. We really back that up because we're putting in almost \$200,000 of our own money in this program, which I think is commendable for a county being as conservative as it is.

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<sup>10</sup>The 1999 Minnesota Round Table, presented by CEED, addressed the topic of "Observation and Assessment of Young Children: Issues in Research, Policy, and Practice." Round Table Speaker Kathryn E. Barnard is a professor with appointments in Parent-Child Nursing, Psychology, and the Center for Child Development and Mental Retardation, University of Washington, Seattle.



Dorothy Liska, Kathleen Speggen, Kathy Jefferson, Lola Jahnke, and Jeanne Marin

We have public health nurses who work with a team of paraprofessional family home visitors, but they have such wonderful tools in this program. I have never seen a program where they have assessment tools and screening tools that, when they go into the home, they work with the individuals and parents and can detect a lot of the issues, problems, and concerns.

Then they have a whole system out there where they measure outcomes. I've never seen a program in social services that really does as much as this does in terms of early detection and then allowing for some kind of assistance in a nonintrusive way because it's a voluntary program. That's an early mental health detection issue. I think that's a program that many counties don't have, but it's something that we need to advocate for and promote. In most of the counties, we deal with crisis.

*The panelists who participated in these conversations represented a variety of services that currently exist in some Minnesota communities. (Please see Appendix C for further information about these programs.) They offer promising models for replication in other communities.*

*But what became apparent as the panels unfolded was that access to these services is very limited and there are some major missing pieces in constructing a continuum of mental health services for Minnesota families with newborns and young children. Defining how to address the missing components of this continuum of services was the goal of the second day of the Symposium.*

# Tuesday Session

## June 19, 2000

On the second day of the Symposium, participants were divided into several small groups to address specific issues related to mental health services for young children —

- Services, Systems, and Funding
- Training
- Public Awareness
- Education and Support
- Advocacy
- Policy Development

These facilitated conversations resulted in an array of recommendations that share common themes regarding availability and funding of services and training for those who provide mental health services to young children and their families and caregivers.

On Tuesday afternoon each group presented their recommendations to Symposium attendees. The recommendations will be used by the Minnesota Infant Mental Health Project in planning for and implementing future strategies and activities to create a framework for mental health services for young children, their families and other caregivers.



Jeanne Martin, Doris Bailey, Glenace Edwall, Robin Exsted, and Kerry Volkers

# Discussion Group: Infant Mental Health Services, Systems, and Funding

## Discussion Group Members

Christopher Watson, facilitator  
Cathy Hansen  
Lola Jahnke  
Dorothy Liszka  
Joan Mick  
Kathy Bushman  
Karen Heyer  
Barbara Belzer  
Kerry Volkers  
Terri Helland  
Karen Lindberg  
Cindy Toppin  
Kathleen Speggen  
Doris Bailey  
Robin Exsted  
Anne Gearity  
Glenace Edwall  
George Realmuto  
Terry Hallfin  
Jeanne Martin

## Recommendations

This discussion group recommended that the State of Minnesota develop a grant process for local communities to identify an individual to be trained as an Infant Mental Health Specialist.

1. Require that grant be built into an ongoing, successful collaborative structure within the community. Let each community decide which structure it would like to use as fiscal agent for the grant (IEIC, collaboratives, etc.).
2. The person nominated to serve as Infant Mental Health Specialist must be linked to the community's collaborative structure identified in #1.
3. Communities should be given the flexibility to define their "community" for the purpose of the grant (using the geographic boundaries or other criteria that make sense to them in defining their community).
4. The role of Infant Mental Health Specialists should be to integrate, coordinate, and develop methods for screening; and provide consultation regarding infant mental health issues to community providers.

5. The training component should consist of a core curriculum delivered to all identified Infant Mental Health Specialists. Training should be supplemented according to individual and community needs and interests.
  - Project Exceptional is one possible model to link people so that a statewide network of IMH specialists exists and is maintained and so that ongoing training can be provided to those in the network.
  - There will be community needs beyond what the Infant Mental Health Specialist can address. By developing this position in every community, service gaps will become more evident, and there will be a need to put other elements in place to fill those gaps.

### **Other Opportunities**

The Children's Cabinet has developed priorities for the next legislative session that mirror those for infant mental health. We need to find ways to become part of this effort. The three priorities targeted by the Cabinet are children's mental health, child welfare, and early intervention. This commitment by the Children's Cabinet represents a wonderful opportunity to move forward.

### **Funding**

- Explore options for coordinated funding pools among social services, education and health, plus foundation and corporate support.
- Explore foundation and grant support: Local community activities are often funded through a combination of private foundation, corporate, and public support.

## Discussion Group: Infant Mental Health Training

### Discussion Group Members

Susan Schultz, Facilitator  
 Scott Harman  
 Joan O'Leary  
 Valerie Ritland  
 David Fisher  
 Connie Abbott  
 Linda Olson Keller  
 Betsy Horton  
 Tom Anderson



Susan Schultz

## Recommendations

This discussion group brainstormed the “who” of training. There is a large and diverse audience for training, including child care staff, families, subspecialists, judges, and members of religious communities. This group put specificity aside and came up with general recommendations.

1. The State of Minnesota will provide leadership in curriculum development and training of interdisciplinary Infant Mental Health (IMH) specialists, including the following content areas:
  - Information/theory base
  - Assessment/screening/referral resources — how you do it, knowledge of resources used
  - Intervention/treatment methods
  - Consultation/supervision/training tools
2. The State will provide leadership in identifying and developing infant mental health education and training materials. There is a need to address the various levels of training — the specialist, the mental health clinician, direct service, child care staff, line staff, and others.
3. The State will provide leadership for professional development/continuing education in the area of infant mental health for professionals working with families of young children with disabilities, and including attention to prenatal issues.
4. The State will provide leadership in identifying and providing an IMH base and skills necessary for direct service personnel working with infants and young children with disabilities and their families.
5. The State will identify a network of individuals with expertise in infant mental health and a mechanism for their provision of consultation to communities. The goal is to support the development of expertise within communities.
6. The State will provide leadership in offering parent and family education for families of infants and young children with disabilities.

## Discussion Group: Infant Mental Health Public Awareness/ Education and Support/Advocacy/ Policy Development

### Discussion Group Members

Michael Eastman and Sue Benolken,  
Facilitators  
Renee Torbenson  
Deanna Steckman  
Jan Rubenstein  
Kathy Jefferson  
Judy Wepplo  
Phyllis Wright Slaughter  
Marilyn Lucas  
Mary Vanderwert  
James Huber



Jim Huber and Michael Eastman

## Recommendations

This discussion group recommended that the State of Minnesota:

1. Develop and support a general awareness campaign regarding infant mental health.
  - State and grassroots partnership needs to be developed.
  - Develop a brochure.
  - Produce a glitzy campaign.
  - Connect with current messages around violence (e.g., Columbine)
  - Stigma issues need to be addressed by talking about infant/children's mental health (e.g., Oprah Foundation 30-minute video that addresses stigma)
  - Emphasize the relevance to families across all socioeconomic levels.
  - There is a need to train and teach about child development.
  - Include information regarding prenatal through early childhood ages.
2. Conduct a public relations campaign targeted at the State legislature and others for specific wants and needs.
  - Advocate for increasing staff and pay for those doing the work (e.g., child care staff).
  - Advocate for universal screening and connections for services.
  - Increase access for the 10% of families who do not want screening for infant mental health concerns.

- Advocate for increased resources for training and expert consultation (e.g., improve access).
  - Encourage universities and colleges to develop certificate programs or degrees in infant mental health (medical schools, social work, education, public health, psychology, nursing).
  - Advocate for a stable “medical home” for each Minnesota family (i.e., a primary care physician).
  - Increase child find (early identification) and finding services for children and families.
  - Advocate for parental leave policies in workplaces.
3. Examine, support, and encourage individual changes needed in State agencies and programs.
    - All disciplines (education, health, social service, etc.) need information on young children regarding social-emotional development and relationships.
    - Connect with licensing and other monitoring agencies to facilitate infant mental health services.
    - Examine policy, procedures and practices (i.e., out of home placements).
    - Connect with interagency efforts and collaboratives.
  4. Create good state and local partnerships (among advocacy groups, local organizations such as Elks and Moose, business groups, JayCees, faith groups).
  5. Assure participation and involvement by members of diverse cultural communities.
  6. We need to acknowledge the tension between looking at addressing the needs of children with disabilities in comparison to the needs of young children in general (healthy child development). We need to address this issue because we want to go down the same road in advocacy and policy development. How are we going to get there together?



# **Appendix A:**

## **Symposium Attendee List**



**Connie Abbott**

Coordinator, Proactive Intervention Program, Anoka County

**Tom Anderson**

Family Resource Worker, Southwest Family Room — Way to Grow

**Doris Bailey, Ph.D.**

Infant Mental Health Specialist

**Barbara Belzer**

Coordinator, Children and Family Mental Health Services Fraser Child and Family Center

**Sue Benolken**

State Program Administrative Coordinator, Minnesota Department of Human Services

**Kathleen Bushman**

Student Services Supervisor, Roseville Area Schools

**Michael Eastman**

Early Childhood Special Education Specialist, Minnesota Department of Children, Families, and Learning

**Glenace Edwall**

Director, Minnesota Department of Human Services, Children's Mental Health

**Robin Exsted**

Teacher/Consultant for Children with Visual Impairments — Developmental Psychology, Anoka-Hennepin School District #11

**Martha Farrell Erickson**

Director, Children, Youth, and Family Consortium, University of Minnesota

**David Fisher**

Family Therapist, Northern Pines Mental Health Center

**Maureen Fuchs**

Public Health Nurse Advisor  
Minnesota Department of Health

**Anne Gearity**

LICSW specializing in Early Childhood Mental Health, Washburn Child Guidance Clinic, U of M Adjunct Faculty, Independent Practice

**Terry Hallfin**

Parent Educator, Fridley Early Childhood Family Education

**Gayle Hallin**

Assistant Commissioner, Minnesota Department of Health

**Cathy Hansen**

Family Support Specialist, Otter Tail — Wadena CAC Head Start

**Chris Hansen**

Early Childhood Special Education Teacher, Carver Scott Educational Cooperative

**Scott Harman**

Program Director, St. David's Child Development and Family Services

**Terri Helland**

RN, PHN, Brown County Public Health

**Sandra Hewitt**

Psychologist, Private Practice

**Karen Heyer**

Coordinator, Anoka IEIC  
Anoka Area Interagency Early Intervention

**Marcy Hjertstedt**

Coordinator, Early Education-Special Education, Independent School Dist. #16, Spring Lake Park

**Elizabeth Horton**

Clinical Social Worker, Psychoanalytic Foundation of Minnesota

**James R. Huber**

Director, Minnesota Department of Human Services, Intergovernment/Management Operations

**Lola Jahnke**

Public Health Social Work Specialist,  
Minnesota Department of Health-  
MCSHN

**Kathy Jefferson**

Program Consultant, Minnesota  
Department of Human Services

**Jane Kretzmann**

Senior Program Officer,  
The Bush Foundation

**Karen Lindberg**

Maternal Child Health Program  
Coordinator, Dakota County Public  
Health Department

**Dorothy Liszka**

Division Director, Family and Children  
Services, Stearns County Human  
Services

**Marilyn Lucas**

Parent Representative, Ramsey County  
Children's Mental Health Collaborative

**Jeanne Martin**

ECSE Teacher/Team Leader,  
ISD #625, St. Paul Schools

**Terri McNeil**

Infant/Toddler Training Intensive  
Coordinator, Minnesota Child Care  
Resource and Referral Network

**Joan Mick**

Proactive Behavior Specialist, Proactive  
Intervention Program, Central Center  
for Family Resources

**Elaine Nelson**

Program Supervisor, ECSE  
ISD #15, St. Francis Schools,  
Anoka Area IEIC

**Pat Nygaard**

State Program Administrator,  
Minnesota Department of  
Human Services

**Joann O'Leary**

Parent-Infant Specialist

**Linda Olson Keller**

PHN Consultant, Minnesota  
Department of Health

**Beverly Propes**

Community Health Consultant,  
Institute for Minority Development

**Peggy Rader**

Communications/Media Relations  
Specialist, Office of Communications,  
College of Education and Human  
Development, University of Minnesota,

**George Realmuto**

Associate Professor of Psychiatry,  
University of Minnesota

**Val Ritland**

Infant/Toddler and Program Specialist,  
Great Lakes QIC-D (Early Head Start)

**Christina Robert**

Assistant to Director, Irving B. Harris  
Center Training Center for Infant and  
Toddler Development, Institute of Child  
Development, University of Minnesota

**Terrie Rose**

Coordinator, Irving B. Harris Center  
Training Center for Infant and Toddler  
Development, Institute of Child  
Development, University of Minnesota

**Jan Rubenstein**

Part C Coordinator, Minnesota  
Department of Children, Families,  
and Learning

**Martha Schermer**

Social Worker, Children's Hospitals  
and Clinics, Minneapolis

**Susan Schultz**

Psychologist, Private Practice

**Veronica Schulz**

Hennepin County Children and Family  
Services, Children's Mental Health  
Collaborative

**Gary Schwery**

Therapist, Psychomotrist,  
Associated Clinic of Psychology

**Carol Siegel**

Clinical Psychologist and Director  
Washburn Child Guidance; Clinical  
Supervisor, Outreach Consultation  
Program

**Marty Smith**

Planning Project Manager,  
Minnesota Department of Health

**Kathleen Speggen**

Interagency Coordinator,  
Anoka Area Interagency Early  
Intervention

**Deanna Steckman**

Foster Care Program Advisor,  
Department of Human Services

**Amy Susman-Stillman**

Program Co-Coordinator,  
Irving B. Harris Center Training Center  
for Infant and Toddler Development,  
Institute of Child Development,  
University of Minnesota

**Herman Ted Thompson**

Private Practice

**Cindy Toppin**

Vice President, Lifetrack Resources —  
Early Head Start

**Renee Torbenson**

Parent/Infant Specialist, Early  
Childhood Family Education (ECFE)

**Mary Vanderwert**

Program Specialist/QIC-D, Head Start,  
Center for Early Education and  
Development, University of Minnesota

**Kerry Volkers**

Healthy Start Coordinator, Anoka  
County Children and Family Council

**Beth Vossen**

Challenging Behavior Consultation  
Program, Dakota County Community  
Services, Dakota County

**Christopher Watson**

Coordinator, Center for Early Education  
and Development, University of  
Minnesota

**Richard Weinberg**

Professor, Institute of Child  
Development, Co-Director, Irving B.  
Harris Training Center for Infant and  
Toddler Development, Institute of Child  
Development, University of Minnesota

**Jill Weiss**

Psychologist, Rondo Early Childhood  
Special Education, St. Paul Public  
Schools

**Judith Wepplo**

Proactive Behavior Specialist, Proactive  
Intervention Program, Central Center  
for Family Resources

**Kristen Wheeler**

Coordinator, Community Support  
Program for Young Children, Central  
Center for Family Resources

**Phyllis Wright-Slaughter**

Supervisor, Research and Policy  
Minnesota Department of Health,  
Minnesota Children with Special Health  
Needs



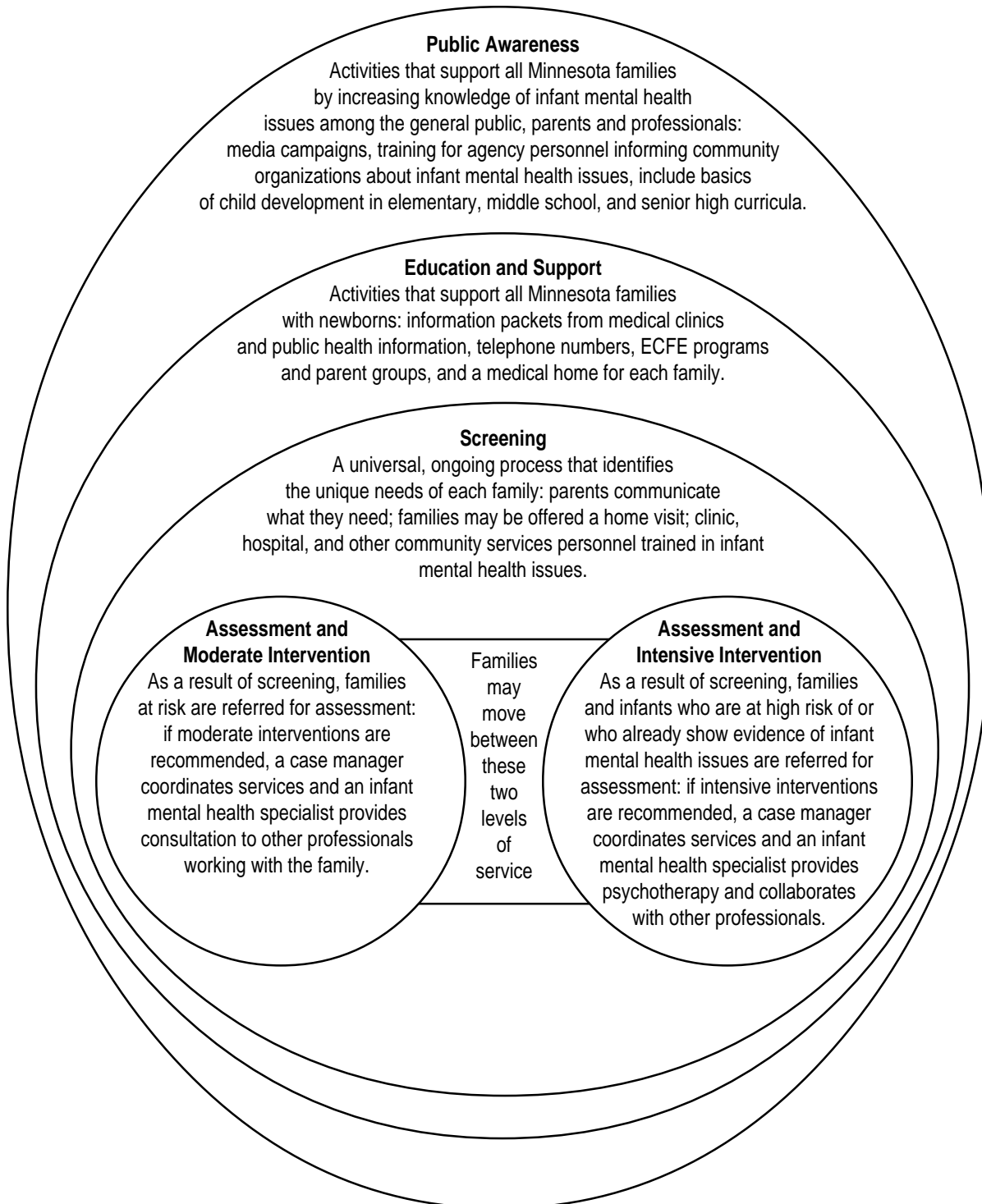
# **Appendix B:**

## **Conceptual Framework for a Coordinated System of Infant Mental Health Services**



# Minnesota Infant Mental Health Service Feasibility Study

## Conceptual Framework for a Coordinated System of Infant Mental Health Services



This model is taken from the *1998 Minnesota Infant Mental Health Feasibility Study*, prepared for the Minnesota Early Intervention Team representing the Minnesota Departments of Health; Human Services; and Children, Families, and Learning. The complete study report and additional information may be found on the CEED Web site at <http://education.umn.edu/ceed>.



# **Appendix C:**

## **Panelist Background Information**



# Tom Anderson

*Family Resource Worker,  
Southwest Family Room — Way to Grow, Minneapolis*

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## **Mission of organization/ program:**

Way to Grow is a community-based organization which initiates the systemic change necessary to promote family-friendly communities and the school readiness of all children. Recognizing that parents are the primary teachers of their children, Way to Grow coordinates informal and formal support systems to assist parents in meeting their children's growth and developmental needs from conception through age six.

## **Sources of funding for services:**

- City of Minneapolis
- Federal money
- State money
- United Way
- Private organizations

## **Distinguishing characteristics of organization:**

We are an agency of the Youth Coordinating Board of the City of Minneapolis. There are currently nine sites in the eleven planning districts providing services specifically tailored to their particular neighborhood.

## **Distinguishing characteristics of services offered:**

We refer participants to existing resources and services to support them in preparing their children for school and also offer a limited range of direct services.

## **Length of time program/ service has existed:**

Way to Grow began 10 years ago.  
Our site was founded six years ago.

## **Population served:**

All Minneapolis families with children ages 0 to 6 years. Universal access.

## **Number of children and families receiving infant mental health services through agency/ organization within a year:**

Through support groups, classes, and one-to-one contact, our site provides services to approximately 200 families and infants.

## **Number of people in agency/ organization involved in this type of work:**

City-wide, Way to Grow has approximately 75 service providers. Our site has seven service providers.

## **How families and children access services:**

We receive referrals from Minnesota Visiting Nurses Association (MVNA), Early Childhood Family Education (ECFE), other human service agencies, direct outreach by staff, and self-referral.

## **Criteria that determine who is served:**

We are a universal access program. Participants must currently be pregnant or have children.

## **Educational and training background of providers who work with families in this program:**

There are no educational requirements (post-high school). Each new employee completes a six-week training before providing one-to-one services.

## Chris Hansen

*Early Childhood Special Education Teacher,  
Carver Scott Educational Cooperative*

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**Mission of organization/  
program:**

Early identification and intervention services for children with special needs and their families

**Sources of funding for services:**

Local, state, and federal education funding

**Distinguishing characteristics  
of organization:**

- Collaborative team approach
- Home-based and family-focused
- Team members that include: early childhood special education teacher, occupational therapy, speech therapy, physical therapy, child behavior specialist, teach of hearing impaired, parents, child care providers, social workers, nurse, interpreter

**Distinguishing characteristics  
of services offered:**

- Early assessment
- Identification of children's strengths and developmental needs
- Home visits
- Collaboration with early childhood family education
- Community health nursing
- Consultation to area child care centers

**Length of time program/service  
has existed:**

Thirteen years with the school district. Services prior to 1987 were county-based.

**Population served:**

Birth to three-year-olds, children with special needs.

**Number of people in agency/  
organization involved in this  
type of work:**

10

**How families and children  
access services:**

Phone call to a central intake and referral program — First Step. Families are also referred by hospitals, physicians, public health nursing, social services, child care centers.

**Criteria that determine who  
is served:**

Early childhood/special education criteria needs to be met for intervention services. Assessment is available for any family/child with concerns about development.

**Educational and training  
background of providers who  
work with families in this  
program:**

B.A. and M.A. in special education and child development, occupational therapy, physical therapy, social work, and communication disorders. Licensure in education.

## Lola Jahnke

*Public Health Social Worker/Follow-Along Program Statewide Coordinator, Follow Along Program and the Minnesota Children with Special Health Needs (MCSHN) Programs at the Minnesota Department of Health*

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### **Mission of organization/ program:**

Early identification of infants and toddlers who are at risk for developmental delay or health issues, through a periodic monitoring and tracking system.

### **Sources of funding for services:**

- Minnesota Department of Health, Title V
- Local tax dollars
- Medical Assistance (M.A.)
- Special Education funding through Part C (for children ages birth to three)
- Private funding
- Insurance

### **Distinguishing characteristics of organization:**

- Local and state partnership
- One method of child find
- Population-based core public health activity

### **Distinguishing characteristics of services offered:**

- Easy to implement
- Cost-effective
- It works
- Voluntary
- Families like it

### **Length of time program/service has existed:**

It was started 12 years ago in southwestern Minnesota and has expanded statewide.

### **Population served:**

Families of children birth to three who are at risk for developmental delay or health issues.

### **Number of children and families receiving infant mental health services through agency/ organization within a year:**

Prevention, screening and referral = all.

### **Number of people in agency/ organization involved in this type of work:**

- Staff in 84 counties and two reservations
- Minnesota Department of Health and MCSHN = 2
- Part C Early Intervention Team = 5

### **How families and children access services:**

Families are referred by hospital Neonatal Intensive Care Units (NICU), physicians, Early Childhood Special Education (ECSE), WIC, Public Health, and by self-referral.

### **Criteria that determine who is served:**

Some counties use specific risk criteria; others enroll anyone who is interested.

### **Educational and training background of providers who work with families in this program:**

Public health nursing, B.A., masters, child development, health education

## Joan Mick

*Behavior Specialist Central Center for Family Resources, Proactive Intervention Program Anoka County*

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**Mission of organization/  
program:**

Lower the number of Early Childhood Family Education (ECFE) referrals for behavior, maintain current child care placement, and provide for success

**Sources of funding for services:**

Local Collaborative Time Study (LCTS) money from school districts funneled through the Children and Families Council

**Distinguishing characteristics  
of organization:**

Collaborative team approach

**Distinguishing characteristics  
of services offered:**

Being able to work directly with children, staff, and parents to help the child be successful and to help staff and parents become aware of community resources that are available.

**Length of time program/service  
has existed:**

Three years, six months

**Population served:**

All children birth to five years of age or first day of kindergarten. However, most are between the ages of three and five.

**Number of people in agency/  
organization involved in this  
type of work:**

Three. However, we have teams that give us additional support.

**How families and children  
access services:**

Parents call if the child is struggling. Also, child care staff can make referrals.

**Criteria that determine who  
is served:**

If the staff has been through the Proactive Intervention Program training, we can work in the setting with the child or work to get the staff trained.

**Educational and training  
background of providers who  
work with families in this  
program:**

Varies greatly.

## Terrie Rose

*Coordinator, Irving B. Harris Training Center for Infant and Toddler Development, Institute of Child Development, University of Minnesota*

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### **Mission of organization/ program:**

The Irving B. Harris Training Center for Infant and Toddler Development is a University/community partnership with a twofold mission: to serve as an information resource for the University and community and to maximize the ability of professionals and organizations to better serve infant and toddler populations.

### **Sources of funding for services:**

One of 10 such centers in the United States and Israel dedicated to the training of professionals in the infant/family field, the center is supported by Irving Harris.

### **Distinguishing characteristics of organization:**

The Harris Center is dedicated to both prevention and intervention in working with infants, toddlers and families. The goal is to provide accessible information and training that promotes effective, responsible, and caring environments for very young children.

### **Distinguishing characteristics of services offered:**

The Harris Center engages numerous projects designed to help parents, professionals, and policy-makers provide optimal support for the healthy development of infants and toddlers. These activities include: conducting workshops, public forums and conferences relevant to current topics in child

development; Training of Trainers program providing leadership training programs for professionals in the infant/family field; service and research programs enhancing the development of infant, toddlers and families.

### **Length of time program/service has existed:**

The Harris Center was created in 1996.

### **Population served:**

Professionals, community members, policy makers, parents, care providers, educators, graduate students, and undergraduate students are served in local and national training activities. In addition, infant, toddlers, parents and siblings are served in service programs.

### **Number of children and families receiving infant mental health services through agency/ organization within a year:**

Several service programs are associated with the Harris Center.

### **Educational and training background of providers who work with families in this program:**

Most of the Harris Center activities are conducted by dedicated individuals who have a Ph.D. in child development and years of practical and research experience. The Harris Center also partners with a wide variety of professionals from public health nursing, early childhood education, and social work.

## **Martha Schermer**

*Social Worker, Children's Hospitals and Clinics, Minneapolis*

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**Mission of organization/  
program:**

Champion children with special health needs and their families.

**Sources of funding for services:**

Insurance reimbursement

**Distinguishing characteristics  
of organization:**

We serve medically fragile, chronically ill children and their families as well as children with acute medical needs.

**Length of time program/service  
has existed:**

26 years

**Population served:**

Pediatrics

**Educational and training  
background of providers who  
work with families in this  
program:**

Varied.

# Gary Schwery

*Therapist, Psychomotrist, Associated Clinic of Psychology*

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**Mission of organization/  
program:**

Psychiatric and counseling services;  
Rule 29 services.

**Sources of funding for services:**

- Insurance
- Private pay
- Grants

**Distinguishing characteristics  
of organization:**

Multidisciplinary team approach.

**Distinguishing characteristics  
of services offered:**

In-home early intervention services.

**Length of time program/service  
has existed:**

The program is in its second year.

**Population served:**

Preschoolers of Dakota County.

**Number of children and families  
receiving infant mental health  
services through agency/  
organization within a year:**

50-70 families.

**Number of people in agency/  
organization involved in this  
type of work:**

Two directly; organization has 45  
professionals.

**How families and children  
access services:**

Referral from early childhood/local  
school district.

**Criteria that determine who  
is served:**

Approximately 50% early childhood  
special education eligible.

**Educational and training  
background of providers who  
work with families in this  
program:**

- Doctoral level psychologists
- Training in child and family services
- Each having 11+ years of in-home  
experience

## Carol Siegel

*Clinical Director, Washburn Child Guidance Center, Infant/Toddler Program, Minneapolis*

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### **Mission of organization/ program:**

- Strengthening relationships between parent and child
- Preventing child abuse and neglect

### **Sources of funding for services:**

County

### **Distinguishing characteristics of organization:**

Nonprofit mental health agency that provides comprehensive services for children and families

### **Distinguishing characteristics of services offered:**

Psychotherapeutic program for parents with serious mental health needs

### **Length of time program/service has existed:**

This version of Infant/Toddler is 10 months old, but there has been an Infant/Toddler program at Washburn Child Guidance Center for approximately 20 years.

### **Population served:**

Low income, high need, high risk parents and children

### **How families and children access services:**

Child Protection Services (CPS), pediatricians, Way to Grow, self-referral, etc.

### **Criteria that determine who is served:**

Have children between 0-36 months, although exceptions can be made for children 36+ months who are functioning below their chronological age. Pregnant women are eligible as well.

### **Educational and training background of providers who work with families in this program:**

M.A.- or Ph.D.-level

# Cindy Toppin

*Vice President, Lifetrack Resources/Early Head Start, Ramsey County*

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## **Mission of organization/ program:**

Early Head Start seeks to enhance very young children's development and promote healthy family functions and self-sufficiency.

## **Sources of funding for services:**

Federal Head Start

## **Distinguishing characteristics of organization:**

- Collaboration with Ramsey Action Programs (RAP) Head Start
- Lifetrack Resources
- Early Childhood Family Education (ECFE)
- Partners with public health and mental health

## **Distinguishing characteristics of services offered:**

Weekly home visiting, focusing on child development, health and nutrition, community resources, and family-to-family support

## **Length of time program/service has existed:**

September 1999

## **Population served:**

Income-eligible families in Ramsey County who are pregnant or have children ages zero to three.

## **Number of children and families receiving infant mental health services through agency/ organization within a year:**

40

## **Number of people in agency/ organization involved in this type of work:**

5

## **How families and children access services:**

Referrals from public health, child protection, Head Start, other community resources, and self-referral.

## **Criteria that determine who is served:**

- Income eligible
- At risk

## **Educational and training background of providers who work with families in this program:**

- B.A. in child development, social work, or related fields
- Experience with families with young children in a home setting

## Renee Torbenson

*Parent/Infant Specialist, Minneapolis Early Childhood Family Education (ECFE)*

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### **Mission of organization/ program:**

Minneapolis ECFE builds and supports the skills and confidence of parents and strengthens families by providing safe and educational environments that promote the healthy growth and development of families with children pre-birth to kindergarten. Specifically, the hospital-based collaborative programming strives to offer education and support to parents of newborn infants as they begin their new relationship and help connect parents with parent support and education programs located in their community.

### **Sources of funding for services:**

ECFE is funded through state-legislated dollars.

### **Distinguishing characteristics of organization:**

ECFE is a universal access education and support program for parents and their children birth to kindergarten.

### **Distinguishing characteristics of services offered:**

Minneapolis ECFE offers a broad range of parent education and support services to meet the needs of the individual community. Classes are offered at neighborhood sites and in collaboration with hospitals, clinics, and social service agencies throughout the community. Specialized programming is offered for Hmong-, Somali-, and Spanish-speaking parents.

### **Length of time program/service has existed:**

The ECFE program has been in existence since 1974. In the past two years, Minneapolis ECFE has expanded its collaboration with the medical community to more effectively reach parents of infants. Classes or individual parent education sessions are offered to parents of newborns during their postpartum stay at several area hospitals.

### **Population served:**

Parents and their children pre-birth to kindergarten.

### **Number of children and families receiving infant mental health services through agency/ organization within a year:**

In the 1998-99 school year, over 5,000 families (parents and infants) received preventative infant mental health services in hospital and neighborhood-based classes through Minneapolis ECFE.

### **Number of people in agency/ organization involved in this type of work:**

Minneapolis ECFE has six full-time parent/infant specialists.

### **How families and children access services:**

Families are actively recruited through a variety of marketing and outreach efforts. Hospital-based classes provide a natural audience for parent education and outreach efforts. Families also access us through agency referrals and word of mouth.

**Criteria that determine who is served:**

ECFE is a universal access program with a sliding fee scale. Fee waivers are available and no one is turned away because of an inability to pay.

**Educational and training background of providers who work with families in this program:**

Minneapolis ECFE infant specialists are licensed parent and/or early childhood educators and receive specific infant training for working with parents of newborns. Most infant specialists have a masters degree and several are also licensed ECSE teachers.

## Kristen Wheeler

*Coordinator, Community Support Program, Central Center for Family Resources, Anoka County*

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### **Mission of organization/ program:**

To provide support and consultation to parents and providers for children (birth to kindergarten) around social, emotional, behavioral, and mental health issues.

### **Sources of funding for services:**

- Anoka County mental health dollars
- Grant from the Minnesota Department of Children, Families, and Learning

### **Distinguishing characteristics of organization:**

Collaborative mental health clinic

### **Distinguishing characteristics of services offered:**

- No referral criteria
- Service can follow child
- Ability to support children and families in any/all settings that children are in

### **Length of time program/service has existed:**

With Central Center, 5 years; previously supported by the Wilder Foundation

### **Population served:**

Any family or provider within Anoka County, birth through kindergarten  
Number of people in agency/organization involved in this type of work:  
One full-time, one-half-time

### **How families and children access services:**

Referrals

### **Criteria that determine who is served:**

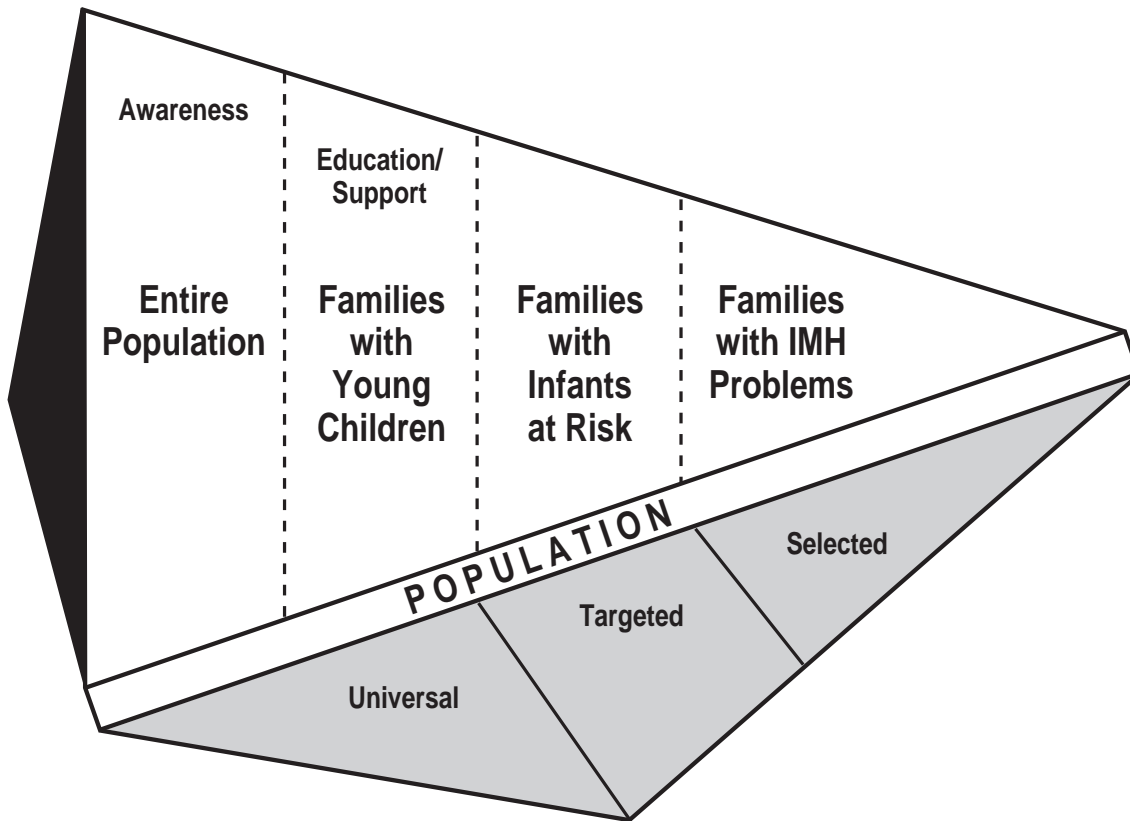
No criteria

# **Appendix D:**

## **Continuum of Service Model**



# Continuum of Services



This model was developed by Terrie Rose, Irving B. Harris Center for Infant and Toddler Development, University of Minnesota.

