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How do California Early Start providers address the social and emotional wellbeing of infants and toddlers with developmental disabilties? : a project based upon an independent investigation

Sarah F. Muchnick
Smith College

Sarah Friedman Muchnick
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Start Providers Address the
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Disabilities?

ABSTRACT

136 providers of services to infants, toddlers and their families were surveyed in

order to gain information concerning assessment and intervention in social/emotional

development and parent/child relationships. Programmatic philosophies were examined,

as well as participants' direct experience with assessment, intervention, access to mental

health resources, and experiences of supervision. Findings revealed an understanding of

the importance of social/emotional development in assessing development and revealed

that educational strategies were used more often than those that addressed the thoughts

and feelings of practitioners and families. A majority of providers received individual

supervision to review cases, but fewer received reflective supervision that addressed the

thoughts and feelings of families and providers.

HOW DO CALIFORNIA EARLY START PROVIDERS ADDRESS THE SOCIAL

AND EMOTIONAL WELLBEING OF INFANTS AND TODDLERS WITH

DEVELOPMENTAL DISABILITIES?

A project based upon an independent investigation,
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Sarah Friedman Muchnick
Smith College School for Social Work
Northampton, Massachusetts, 01063

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CHAPTER I

INTRODUCTION

Federal law: IDEA Part C

The Individuals with Disabilities Education Act (Part H) (now Part C) (IDEA; 20;

U.S.C., Section 1431 et.seq.1997) was originally signed into law in 1986. It was

extended in 1997 and went into effect July 1, 1998 Regulations were finalized in March

1999. IDEA Part C was extended in 2004 to encourage, though not require states to

expand eligibility criteria. In 2007, new revisions were recommended but have not yet

been implemented.

IDEA Part C provides funding to the states for educational and therapeutic

services for children from birth to age three who have developmental disabilities or

delays or, in some states, those who are at risk for developing disabilities. Individual

states are not required to participate in Part C, but currently, all fifty states provide

services in conformity with the federal law. States have been given wide latitude in the

design of Part C Programs.

The creation of IDEA was influence by three factors. First, in response to

increasing pressure from parents, the law emphasizes that services to infants and toddlers

be "family-focused." This signified a major shift from services that historically had been

developed without significant parental input. The centerpiece of family-focused services

is the Individual Family Service Plan (IFSP). Part C states that parents are to be equal

partners in the IFSP process, and requires that each child's family be integrally involved in assessment, program planning, and implementation of services. Goals set at the IFSP meeting are parent-generated and must be reviewed at least every six months. As part of the family focus, parent-run resource centers is also required and generally consists of a resource library of available educational materials, peer-to-peer support, support groups and assistance with advocacy.

The second important impetus for Part C was the de-institutionalization movement of the 1980s. The language of Part C stresses the goal of maintaining children in their homes with the same services that would be available in an institutional setting. The law specifies that Part C funding extend to special education teachers, speech therapists, occupational and physical therapists, social workers, psychologists and family therapists. Part C required that each participating state designate a lead agency to administer its program. That agency varies from state to state, and includes departments of health, departments of education, and other agencies, as each state deems appropriate.

California State Law (CEISA).

The third factor influencing the passage of IDEA Part C was the increasing understanding of the benefit of early intervention (EI). The great goal of Part C was to address developmental delays early so that children would be ready and able at age five to mainstream into public schools with no need of special education.

California law - CEISA

The California State Legislature passed the California Early Intervention Services Act in 1993 (CEISA; 14 G.C. Section 95000 et seq.). CEISA established state authority to develop an EI service system that was congruent with federal requirements. The

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California Department of Developmental Services (DDS) plans, develops, implements, and monitors the statewide early intervention services system. DDS policy includes collaboration with the California Department of Education (CDE), and with advice and assistance from the State Interagency Coordinating Council (ICC). The Departments of Health, Social Services, Mental Health, and Alcohol and Drug Programs cooperate and coordinate with DDS and CDE in the delivery of early intervention services. State regulations governing Early Start were approved in August 1998 and are found in Title 17, California Code of Regulations, and Section 52000 through 52175.

The Mechanics of California Early Start

California Early Start created nineteen Regional Centers throughout the state to procure and implement services required by Part C. The Regional Centers are private non-profit agencies and receive their funding from the Department of Social Services. Service coordinators, also called counselors, are Bachelor's or Master's level social workers. The counselors are responsible for holding IFSP meetings, contracting with service providers, and for overall case management. Designated service providers are contracted to function as vendors under the aegis of the Regional Centers. Vendors range from individual practitioners to large non-profit agencies.

School-based Early Start services are administered by Lead Education Agencies (LEA's) and receive funding through the State Department of Education.

This Researcher worked for a dozen years in California Early Start, first as an individual vendor, then as owner/director of a small intervention agency, and finally as an "in-home teacher" for a national non-profit agency. In all of these roles, there was much opportunity to observe the implementation of IDEA Part C and CEISHA. In terms of

evaluation and service planning, California Early Start adheres strictly to the Part C guidelines. Following an eligibility evaluation, parents and counselors meet for an ISFP, which complies with all Part C requirements. Parents are asked to articulate goals for their children in each of five developmental domains – motor development, cognition, speech, self-help skills, and social/emotional development. Parental goals for his/her disabled infant or toddler were often poignant: "I want her to be happy," or, "I want her to walk and talk," or, "I want her to grow." It is then the job of the services coordinator to help develop measurable six-month outcomes such as, "J will crawl forward on his belly," or, "L will babble several consonants," or "S will eat pureed fruit and cereal."

Once these outcomes are set, specific services are agreed to. The providers of those services are then required to assess the child's progress every six months, before the IFSP review. As a result of this domain-specific focus, services are often provided by a variety of specialists -- speech therapists, occupational therapists, teachers, and the like -- - each working on specific goals in his or her domain. Interventions are focused on the achievement of ISFP goals. For example, a teacher might work on goals such as "draws a vertical and horizontal line, "and "stacks three blocks," and "finds a toy hidden under two covers." An occupational therapist might work on a goal such as "holds cup and drinks." A speech therapist might have goals such as "babbles several consonants" or "complies with two-part directions."

The Missing Link in Provision of Services

The attainment of domain-specific skills surely points to developmental progress. But have service providers been in a position of not seeing the forest for the trees? This

writer recalls several families with needs were far greater than the attainment of developmental markers.

Here is one example: The "consumer" was a little girl who, for the purposes of this study, will be called Jenny. Jenny was the sole surviving triplet of first-time mother, whom I will call Ellie. One of the triplets spontaneously aborted at 23 weeks. Jenny and her remaining sister were born at a gestational age of 25 week. Jenny's remaining triplet died three days following birth.

After many weeks in the neonatal intensive care unit, Jenny arrived home with a variety of serious medical needs. She required oxygen to assist her immature lungs; unable to suck, she was fed through a tube in her stomach; and she was below the first percentile for height and weight. Shortly after birth, she had eye surgery to remedy impaired vision, and her vocal cords were accidently cut during intubation. The result was she could not vocalize. Her body was rigid, and sometimes shook violently suggesting possible neurological damage. Jenny received every service the Regional Center had to offer: She had weekly visits with an educational specialist, a speech therapist, an occupational therapist, a vision specialist, a physical therapist, and a feeding specialist. Each provider worked with Jenny to achieve the goals described on her IFSP.

One service that was not offered was intervention to address Jenny's social/emotional needs, Ellie's extreme guilt and anxiety, and the effects of Jenny's medical and developmental problems on infant-parent relationship. Jenny's mother was overwhelmed with Jenny and the demands of her treatment. She appeared extremely frail and anxious. She was underweight, and exhausted. Try as she might, she was unable to soothe her vulnerable child whose face and body language frequently showed great

distress. Ellie's husband, whom I will call James, appeared depressed and grief-stricken at the loss of Jenny's sister and of the healthy child he had imagined. Ellie and James fed Jenny every four hours by pushing donated breast milk through her G tube, but Jenny immediately vomited almost all of every feeding. Because Jenny could not vocalize, she was unable to give clear cues to her parents who were increasingly worried and overwhelmed. Ellie and her husband were chronically sleep-deprived as they took turns staying awake all night to monitor Jenny to make sure she did not aspirate her vomit. During the day, Ellie and James were consumed by bringing Jenny to her many therapeutic and medical appointments. Meantime, both parents were working full-time jobs.

Merely following the goals of the IFSP seemed absurd. It was clear that Ellie and James's grief, trauma, and overwhelming feelings of failure and loss had to be addressed. Their interactions with Jenny were fraught with confusion and fear and Jenny's attachment to her parents seemed tenuous at best. Jenny disliked being held, and every time she arched away from her mother, Ellie winced and expressed her fear the Jenny had not attached to her, or worse, that Jenny was autistic. Ellie and James's sense of ineffectiveness and lack of belief in both themselves and their child indeed seemed to contribute to Jenny's lack of attachment behaviors. She seemed to barely notice her parents' comings and goings, did not follow her parents when she first learned to crawl, and rarely sought comfort when distressed. Not surprisingly, Ellie and James's marriage was under a great deal of stress. One area of contention was Ellie's wish to have another - healthy -baby, and James's conviction that they could not manage the demands of another baby.

Jenny sought out support groups for mothers of children with special needs, and another group for mothers of children with G-Tubes. She found these herself, without assistance from the Regional Center or the Family Resource Center. Respite care was offered by Regional Center, and the nurse who visited several times a week made it possible for Jenny to work. While the nurse's relaxed expertise was welcome, at the same time Jenny's sense that a stranger was able to care more effectively for her child than she was increased her low self-concept as a mother. The many service providers were a group of extremely empathic individuals, and proficient in their fields. However, none were trained to address the numerous family issues that presented.

The Primacy of Relationships in Early Development

Research has firmly established not only the necessity of warm, reciprocal relationships between infants and parents to ensure emotional and psychological health (Ainsworth, 1978; Bowlby, 1969; Council and Institute of Medicine, 2000; Fraiberg, 1980; National Research Zero to Three Policy Center, 2004; Spitz, 1946). Further, it has been well documented that the quality of a child's early primary relationships has a powerful effect on all other areas of development (Dodici, Draper, & Peterson, 2003; Feldman, Weller, Leckman, & Kuint, 1999; Lerner & Ciervo, 2004; National Scientific Council on the Developing Child (2004); Tamis-Lamonda, Bernstein, & Baumwell, 2001). Infant development, then, is transactional. That is, developmental achievements in infancy and toddlerhood result from the quality of transactions between parent and child in all developmental domains.

The study reported here involved surveying Early Start providers to gather information about their assessments and interventions in social/emotional development

and the supportive services they receive. This researcher was particularly interested in providers' understanding of the role of social/emotional development of infants and toddlers in their overall development, and their understanding of the primacy of relationships in social/emotional development, and how that understanding affects the interventions and services they provide. An important aim in this study was to determine whether a relationship-based focus is present in the interventions that children like Jenny receive in California. The following Chapter (II) reviews the research literature pertinent to this topic; Chapter III presents the methodology for this study. Chapter IV details the findings of this study, and in Chapter V there is discussion pertinent to the implications of those findings for social workers and others who serve special needs infants and toddlers.

It has been a hope that examining California Early Start will have implications for other states with similar EI programs with, presumably, similar strengths and similar challenges. If so, this study may shed light on the field of early intervention that will be of use to states around the country as they strive to meet the needs of children with disabilities and their families.

CHAPTER II

LITERATURE REVIEW

IDEA Part C was designed to assist states in providing a "statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with disabilities." The philosophical underpinning of the bill was a "family-centered" approach. The notion that the family, not just the disabled infant, should be the recipient of services was a radical departure from the traditional approach of directing services solely to the infant. The intent of the law was to ensure that the family becomes the active decision-maker in the child's life, and that the family's vision of the child's future directs programming (Baird & Peterson, 1997). The vision of IDEA Part C was one of collaboration and respect for the context of the child's development.

At the same time, research has increasingly shown that the infant-parent relationship is paramount to early development (Goldberg, 1977; Klein & Provence, 1990; Sameroff, 1993; Wieder & Greenspan, 1987).

There is a palpable tension between these two perspectives (Baird & Peterson, 1997; Gilkerson, & Stott, 2005). If parents are to determine services, is it compatible for service providers to include interventions targeting the parent-child relationship? If families' cultural preferences are to be respected, do providers have the right to question child-rearing styles? If providers attempt to enter the realm of parent-child relationships,

do they have the professional training and support needed to intervene in interactions that are fraught not only with individual and cultural differences, but also with the emotion-laden memories and beliefs that inform parenting?

Gilkerson and Stott (2005) describe two distinct schools of thought concerning relationship-based programming for infants. The first is an "infant mental health" approach, which they describe as "working in the relationship"; the second is an infant-parent interaction approach, which they describe as "working through the relationship."

Heffron (2000) defines infant mental health as a three-part approach to services. The first, "Promotion" refers to efforts to widely disseminate the idea that strong parent-child relationships are essential to development. The second, "Relationship-based preventive intervention" refers to shifting the focus of professionals and paraprofessionals working with infants and their families toward the parent-child relationship. Heffron warns that this would entail training, support, reflective supervision, and clarity about boundaries. The third, "Treatment" refers to psychotherapy for parents and children provided by trained and skilled clinicians.

Heffron's (2000) article raises some serious and difficult issues that must be overcome if intervention programs are to take an infant mental health approach. That is, how can or should an infant mental health approach be implemented by professionals and sometimes paraprofessionals who are not trained as therapists? What training would be appropriate? What would intervention from an infant mental health perspective look like in a home visit with a child development specialist, or in an occupational therapist's office? Heffron recommends that home visitors, for example, use skills such as empathic listening, validation, and offers of concrete assistance. This seems, however, to side-step

the issue of how to bring a relationship-based focus to services for children that are supposed to be family directed and have traditionally been delivered along a purely educational and often directive model.

Gilkerson and Stott (2005) contrast the infant mental health ("in the relationship) approach with the "parent-child interaction" approach ("through the relationship"). Parent-child interactions programs focus on helping parents and children to enjoy working and playing together. Intervention centers on the content of interactions between parents and children rather than the meaning of the relationships emphasized in the infant mental health paradigm.

Gerald Mahoney and his colleagues have studied the infant-parent interaction model extensively. Mahoney, Boyce, Hewler, and Spiker (1998), re-examined the results of four early intervention research programs, using the Maternal Behavior Rating Scale. The results of the re-examination suggest that the only factor with an impact on developmental gains was increased maternal responsiveness. The finding is especially interesting in that of the four programs, only one specifically targeted maternal responsiveness in the original study. The authors discuss the prevalence of a child-focused approach in most early intervention programs. They describe various features of a child-focused approach: often, professionals work directly with the child, working to achieve skills in various developmental domains; often, parents are taught to teach their children specific skills. This, the authors argue, results in a focus not only on the child alone, but also on a directive approach that has been found to be counterproductive to children's development. The authors review the reasons that programs have been reluctant to use a model that focuses on parent responsiveness, even though this attribute

has been shown in numerous studies to be the greatest indicator of positive outcomes for children. First, it has been argued that impinging on parents' styles of parenting might result in insensitivity to cultural norms; second, some have argued that children with special needs require a more directive approach than typically developing children do; and third, that professionals would have to be re-trained in order to shift away from the directive model. While the authors feel that these might be legitimate concerns, they believe that they arise from limited understanding of the interactional phenomena being discovered through parent-child research.

Barrera, Rosenbaum, and Cunningham (1986) compared the effects of two types of in-home intervention with low birth weight infants with each other, and with two control groups -- one preterm and one full term -- receiving no intervention. The two types of intervention studied were an intervention focused on developmental skill acquisition and an intervention focused on infant-parent interaction. In the developmental program, the goal, like that of the Part C programs in which this researcher has participated, was to improve the child's developmental level of functioning. In the parent-infant intervention program, the goal was to improve the quality of interaction rather than to teach specific developmental skills.

The researchers found that there was a stronger effect in the group that used a parent-infant approach than in the group using a child development approach. They found a significant difference in the amount of gain in cognitive, language, social, and emotional development in the parent-child interaction group over the developmental group. The preterm infants in the control group (normal birth weight infants) and the

infant-parent group all showed consistency in the motor index, while the developmental group made gains in their motor development.

On social and emotional scales (the HOME inventory and in coded observations of parent-infant interaction), the infant-parent group showed marked improvement compared to the preterm control group and to the developmental group. The results suggest that a combination of intervention approaches might be useful for addressing different areas of development in preterm infants. The infant-parent interaction approach seemed to have a greater effect on cognitive, social, and emotional skills, as well as on maternal responsiveness and flexibility than did a developmental approach. However, a more traditional task-oriented approach to motor development might be necessary to help preterm infants overcome motor disabilities and delays. Mahoney (1998) believes that even when a child-focused approach appears to result in more motor gains (e.g., as happens in individual physical therapy), the parent's experience as an onlooker in task-oriented skills can be undermining to the parent's sense of competency and to the parent's relationship with the child.

Both the Zero to Three Policy Center and the Infant Toddler Coordinator Association (a group comprised of all fifty state Part C coordinators) advocate adoption of an infant mental health approach.

The Zero to Three Policy Center (2004) published a "fact sheet" for policy makers, urging that all programs for young children emphasize healthy social and emotional development. Their summary recommendations are as follows:

1. Integrate infant and early childhood mental health into all child-related services and systems.

2. Assure earlier identification and intervention of mental health disorders in infants, toddlers and their parents by providing child and family practitioners with screening and assessment tools.

3. Develop system capacity through professional development/training of service providers.

4. Assure comprehensive mental health services for infants and toddlers in foster care.

5. Provide infant/toddler childcare programs with access to mental health consultation and support.

The first of these recommendations is especially salient in services for children with disabilities. The writers specifically recommend that Part C Early Intervention include linkages to mental health systems, and that Part C services provide ongoing training and personnel development to address mental health.

The Infant and Toddler Coordinators Association (2006) published a position paper titled, "Infant Mental Health Approaches and IDEA Part C" in which they called for a coordinated effort on the part of State and Federal agencies to fund infant mental health services for Part C programs.

Odom and Wolery (2003) took on the daunting task of defining a "unified theory of practice in early intervention/early childhood special education (EI/ECSE)." Odom and Wolery identified eight precepts of good practice:

1. Families and homes are the primary nurturing contexts

2. Strengthening relationships is an essential feature of EIECSE

3. Children learn through acting on and observing their environment

4. Adults mediate children's experiences to promote learning

5. Children's participation in more developmentally advanced settings, at times with assistance, is necessary for successful and independent participation in those settings

6. EI/ECSE practice is individually and dynamically goal oriented

7. Transitions across programs are enhanced by a developmentally sensitive orientation

There has been some research that looks specifically at the impact of an infant's disabilities on parenting capacities. Howe (2006) reviewed research examining the relationship between disabilities and attachment behavior in young children. Several studies have demonstrated higher levels of insecure attachment among toddlers with disabilities, although a significant number of children with disabilities demonstrate secure attachment. Howe found that certain factors appear to put children with disabilities at an especially high risk for insecure attachment. First, a mother with a difficult and unresolved attachment history is less likely to respond sensitively to her child with a disability. Second, children whose sensory and communication skills are compromised by their disabilities tend to elicit less attuned maternal behavior. Third, parents who are "unresolved" about their children's disabilities show less attuned caregiving. The authors do not clarify the definition of "resolved," but this researcher posits that they are suggesting that the diagnosis is accepted. The author notes that the specific disability and its severity also have an impact on attachment and maternal responsiveness. For example, parents of children with an unclear prognosis tend to have a harder time being

responsive. Howe recommends interventions in seven areas to assist parents in ensuring

secure attachment to their disabled infants:

1. Assistance in material and economic circumstances

2. Achievement of good social support

3. Receipt of clear explanations of the child's disabilities and the impact on the

    child's ability to communicate needs and emotions

4. Assistance in resolving issues of loss and trauma including the diagnosis of

    disability

5. Help for "insecure parents" to reflect on and reprocess attachment issues

    relating to their own childhood experiences

Howe (2006) goes on to state, "We need to be aware of the special needs not only of

infants but also of parents who are relatively unskilled in nurturing a difficult baby… ."

Howe further suggests that further research contain outcome measures of parental

changes such as self-esteem, confidence, or stress.

This study gives some confirmation to Barrera's findings, showing that the quality

of infant-parent interaction has a stronger effect on outcomes specifically for preterm

infants than the traditional task-oriented approach of most early intervention programs.

That, in turn, suggests that the needs and abilities of mothers to interact effectively with

their infants should to be given a great deal of attention when designing intervention

programs for infants with special needs.

Spratt and Macias (2007) examined parenting stress in parents of children with

special needs (CSN). They looked at four different populations of CSN: child patients

from a Developmental/Behavior Clinic who had a variety of developmental, neurological,

emotional and/or behavior (DBC) problems; children who had suffered intraventricular hemorrhage (IVH); children seen in a developmental clinic for children with learning and/or attention problems; and children with neural tube defects (NTD). The most salient finding was that in the DBC, IVH and NTD samples, parents with children who had behavior problems only or combined cognitive deficits and behavior problems had the highest stress levels. One interesting finding was that for parents of the children seen in the Developmental/Behavioral Clinic, personal distress was positively correlated with IQ – that is, the higher the child's IQ, the greater the parent's distress. The author conjectures that the parents who had no specific reason to anticipate developmental difficulties (i.e., their children did not have a recognizable disability in the neonatal period) had been unable to adapt their expectations when their child's development veered off. The authors argue that there is an "urgent need" for mental health screening and support for families who are not developing or behaving typically. They recommend psychological screening and assessment for all parents of children who face developmental challenges.

The distinction is very clear when one reads the longitudinal study of Part C programs released in 2007 (Hebbeler, Spiker, Bailey, Scarborough, Malik, Simeonsson, Singer, & Nelson, 2007). Much of that report looks at "child outcomes" and "family outcomes." The 116-page report documented that "children who receive Part C services experienced a range of outcomes, including a sizable percentage of children who were doing as well as their same-age peers by kindergarten" (p. 5-16). However, some serious lacks in EI program were identified. A section titled, "Social Emotional Problems: Present yet Invisible," it was noted that 32% of families reported that they "often had a

difficult time figuring what to do about their children's behavior" (p. 5-7). One of the

conclusions of the study is that while children saw an average of six professionals while

in early intervention programs, those services were most likely given by a special

educator or child development specialist, along with occupational, physical, and speech

therapists. The study concludes, "It is reasonable to speculate that EI as a field lacks

personnel with the necessary training or background to identify or address issues related

to socioemotional behavior… ." (p. 5-8).

The Hebbler et al. (2007) study did not look extensively at the quality of the

services provided. According to Hebbler et al. (2007):

> The essence of EI is the interaction between the family and the
> professional and information at that level was not available. We do not
> know from NEILS what providers were trying to address through their
> interventions or how they were doing it (although we do know that far too
> many were working with just the child. (p. 5-17)

The writers recommend that how EI services are implemented requires "more in-depth

information about the nature of the interactions that constitute EI services" (p.5-17).

In reviewing the literature, this researcher has uncovered little exploration of how,

in fact, EI services are implemented with the exception of the work of Gerald Mahoney

and his colleagues. Mahoney and Bella (1998) examined the implementation and effects

of family-centered early intervention in thirty-six programs in five states. Their concern

was whether the philosophy of family-centered services (which the authors support in

principle) was having the predicted effect on family functioning and on child

developmental outcomes. Unfortunately, the study showed no effects of family-centered

services, at least in these thirty-six programs, on either child or family outcomes.

Mahoney's numerous studies, including the multi-site study cited above, all point to the

necessity of making sure that the family-centered approach is grounded in an understanding of the importance of the quality of the child's early relationships. Taken together, the research of Mahoney and his colleagues seems to indicate that "family-centered" services are not being implemented with regard to such attributes as maternal responsiveness, which he and others have shown to be correlated with increased outcomes.

If a shift to a relationship-based approach in EI is to happen, it is important to examine, as Mahoney has begun to do, how services are actually implemented. The thesis project reported here explored implementation from the perspective of front-line practitioners in EI in an effort to contribute to the knowledge of the current state of the field with an eye to how changes might be made to move toward a norm of relationship-based services.

Staff support and supervision

The term "reflective supervision" (RS) was first used in the child development field in a 1990 article in Zero to Three, then called the National Center for Clinical Infant Programs. (Fenichel, Eggbeer, & the TASK Advisory Board, 1990). The authors proposed that all programs serving infants and toddlers provide supervision akin to the clinical supervision received by clinical mental health trainees. Their vision was to use supervision as a means to two critical goals: to build greater quality in programs, and to provide apprenticeship-like training to all providers in a wide range of programs and disciplines.

The perception of the need of staff for reflective supervision arose from the recognition of the complexity of work with infants and families. The problems presented

in the field required more than concrete knowledge in a specific field. (Weston, 2005).

Providers in all kinds of infant programs found themselves working with families in crisis

and families with a variety of challenges including poverty, racism, disabilities, family

problems, and difficulty negotiating systems of care. The questions that arose were:

How can providers gain tools to address complex issues? How can programs support

providers as they navigate through the distress of working with such vulnerable

populations? How can programs gain the capacity to serve the very diverse and

complicated needs of the families they serve?

Rebecca Shahmoon-Shanok (2009) describes Fenichel's (1992) original conception of

reflective supervision containing three key concepts:

- Reflection – The stepping back from the work to consider multiple perspectives
  including looking at the observations, thoughts, and feelings of each participant in
  services (supervisee, parent, child, and others).

- Collaboration – a respectful, mutual exchange that relies on full participation of
  both supervisor and supervisee.

- Regularity – predictable routines and valued time for supervision.

That all development is relationship-based has become accepted, at least on a

theoretical basis. Yet, the relationships within agencies, and the relationships between

providers and parents have, in this writer's experience, been rarely addressed.

In the late 1990's a large study was undertaken by the Erickson Institute, Zero to

Three, the Ounce of Prevention Fund, and others interested in infant research and

programming. The purpose of the study was to assess the needs of families served by

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Part C in the state of Illinois. The findings of the Unmet Needs Project were presented in 2002 (Cutler & Gilkerson, 2002). The study comprised numerous sub-studies. Of great interest to the present study were the findings of a parent survey. The findings included the following:

- Almost 50% of these parents stated that their child had behavior problems for which they needed help in managing. Difficulties with sleep or feeding were the most frequently cited issues, but a wide range of behavioral issues was mentioned.

- Early intervention providers were cited as the chief source of help for parents regarding behavioral issues, followed by physicians, family members and friends. Half of the families voiced a need for counseling services to help their family handle their child's behavior problems.

- When asked what would improve the quality of life for their children, families mentioned the need for improved qualifications of the therapists working with their children and the need for support groups for families.

A mental health team was formed, and a sub-study looked at the mental health needs of the children, and program staff's responses to those needs. There were several significant findings:

- 16% of infants and toddlers in programs surveyed have social/emotional/behavioral concerns. While most of these were concerns that respond to regular program services, 7% were severe, requiring additional intervention and/or urgent care.
- Over 40% of childcare programs have had to ask a child to leave the program because of social/emotional/behavioral problems. In group care, the most challenging behaviors are biting, hitting, and aggressive behavior.
- Programs serve families with mental and behavioral health problems. The

greatest challenge for staff is working with families where there is mental illness, child abuse or neglect, or domestic violence. Program staff most want specially trained staff or consultants to work with them on an ongoing basis around these difficult challenges.

- Only 30% of programs reported they were adequately prepared to meet the social/emotional mental health needs of children and families they serve. 80% of programs identified training in infant mental health as a priority for staff development.

- 62% of the communities do not have adequate services to meet the mental health needs of infants, toddlers and families.

These findings pointed to a great need for a new focus on the needs of parents, the social-emotional needs of children, and the need for greater support to both parents and staff. The many stakeholders agreed that a new look at the state's Part C program was warranted. Thus, a system-wide change was undertaken. Through collaboration between the mental health team and program administration, a model of reflective process was undertaken. The mental health team began regular consultation with program administrators, who in turn made regular time to engage in reflective conversations with those who supervised case managers. It was hoped that a more open, reflective, and satisfying work environment would result, and that as a result of taking the time to reflect on their own observations, thoughts and feelings, case workers would be more attuned to relationship issues with the families they worked with, and that parents would be more attuned to the relationships with their infants and toddlers.

As a result of the Unmet Needs Project, a pilot project was begun. (Gilkerson & Kopel, 2005). The project contained ten key elements:

- A social-emotional specialist at entry point in early intervention

- Training in relationship-based early intervention

- Reflective consultation for leadership

- Social-emotional screening of all children at intake

- Integrated assessment and intervention planning

- Regular case consultation

- Bimonthly integrated provider workgroups

- Parent-to-parent support mini-grants

- Social-emotional specialist network

In the review of the pilot project, it was found that all ten elements had been successfully implemented. Of special note is the response of the staff, system-wide to reflective process. Supervisors reported that regular consultation was the most beneficial element of the pilot program. They specifically mentioned the benefit of having regular, designated time for consultation, and the role of the mental health consultant in thinking through agency issues. Case workers cited the benefit of having the time and space for discussing their own responses to highly charged emotional situations with families and, as one caseworker noted, she was able to "learn to work appropriately in spite of my own affect." (Gilkerson & Stott, 2000, p. 357). Workers at all levels reported feeling more appreciated and respected for the difficult work they do, and reported that reflective process had increased their understanding of one another and their communication.

The Illinois pilot program has been implemented statewide. Every state Part C program now has reflective process as its base, with a mental health specialist at each site, and reflective supervision at all staff levels.

While some states, including California, have developed initiatives to address social-emotional needs, there appears to be little momentum toward reflective practice. Possible reasons for this reluctance may be a suspicion of psychology based on an association with the past "blame the mother" thinking of prior decades; a concern that reflecting on process may cross the line into judgment of families' beliefs and culture; and a long-standing sense that providers should maintain "objectivity" in their interactions with families. (Gilkerson & Stott, 2000).

Some writers have worked to make more incremental steps toward reflective process. For example, Pawl and St. John (1998) wrote, "How you are is as important as what you do." This article used case vignettes to illustrate the effectiveness of curious observation and questions in work with families. Mary Claire Heffron and her colleagues at Oakland Children's Hospital have written about use of self in early intervention. These writers have emphasized the necessity of supervision to help providers "create shared awareness, opportunities for self-examination, and increased understanding."

If early intervention programs wish to adopt a relationship-based approach, they must begin in valuing the relationships between front-line workers and their supervisors, and between staff and parents. The implementation of regular, collaborative, reflective supervision paves the way to addressing the real, complex needs of families with vulnerable infants.

Necessity of the Current Study

A review of the relevant literature has revealed extremely limited examination of how early intervention providers actually address the needs of the families they serve. What do providers believe about the relative importance of social-emotional development? Do they normally assess social-emotional development? What interventions do they typically use? What services can they offer families who are in need of mental health services? What opportunities do they have to discuss the families they work with? Do they have opportunities to reflect on the meaning of parents' and children's behavior? Do they have a safe place to explore their own thoughts and feelings about emotionally charged interactions?

CHAPTER III

METHODOLOGY

This quantitative exploratory study was an investigation into how early

intervention practitioners in the state of California address the social and emotional

development of the infants and toddlers they serve. The study utilized an investigator-

developed questionnaire (Appendix A). The questionnaire was posted on an internet site

called SurveyMonkey©. SurveyMonkey© absolutely encrypts all information pertaining

to the identities of the participants. The only demographic information collected

concerned each participant's level of education, number of years providing services to

children ages zero to three, and the type of setting in which each one worked (e.g., non-

profit agency, private office, etc.).

The investigator received approval of the proposed project and all assessment or

recruitment and consent materials from the Smith College Human Subjects Review

Committee (Appendix B) to ensure the protection of all participants. In order to proceed

with the questionnaire, prospective participants were required to read and electronically

sign a letter of informed consent (Appendix C) and affirm that they currently provide

services under the auspices of California Early Start, the state administrative body that

administers and funds all early intervention to infants and toddlers with disabilities in the

state of California. Initially the questionnaire allowed participation only to providers

funded through the Regional Center. It was later expanded to include providers in

school-based programs funded by Lead Education Agencies (LEAs).

Sample

Participants in this study were persons who currently provide direct services to

infants and toddlers under the administration of California Early Start, the California

program designated to provide services under the Individuals with Disabilities Education

Act (Part C). Qualified participants were those in a variety of fields including special

education, speech therapy, occupational therapy, physical therapy, nursing, case

management, clinical social work, psychology, and medicine. As noted above, the

sample was acquired through an internet query. The investigator developed two separate

email queries – one for program directors, (Appendix D) and the other for direct

providers of services (Appendices E and F).

Data Collection

To recruit participants, the investigator utilized professional contacts at various

agencies she was familiar with in the Los Angeles and San Francisco Bay areas.

Additionally, queries were sent to a variety of clinics throughout the state that were found

via internet search. Finally, queries were sent to state Regional Centers.

The investigator made follow-up telephone calls to further describe the nature and

purpose of the study to program directors and administrators. Prospective participants

were also given the investigator's contact information to use if there was a need for

clarification of the study's purpose, or specific questions related to qualification or other

aspects of the study. No identifying information was requested or retained by the

investigator in the course of email correspondence or telephone calls.

One especially fruitful contact was the Infant Development Association of California (IDA). IDA is an advocacy and education network of early intervention providers and interested others. The program administration has had a sustained interest in social-emotional development of infants and toddlers and agreed to distribute the questionnaire to their membership. It is estimated that approximately two thirds of participants received the investigator's query from IDA. The questionnaire was entitled *How Do Early Start Programs Address the Social and Emotional Needs of Infants and Toddlers?* It asked twenty questions falling in five areas:

1. General information including primary field of expertise, level of education, current type of work setting, and years of experience working with children ages zero to three

2. Beliefs of Early Start agencies regarding social and emotional development

3. Assessment and intervention strategies for social and emotional development

4. Access to mental health resources for families

5. Types of supervision received by providers

Finally, there was an open-ended question requesting additional comments regarding social/emotional development and child/caregiver relationships. SurveyMonkey© provided an Excel file summarizing the results, and the Statistical Analyst at Smith College provided further descriptive statistics.

CHAPTER IV

FINDINGS

It has become an accepted fact that a child's social functioning and emotional
health have a decisive impact on development. Moreover, the development of social
competence and emotional security appear to depend upon a warm, secure, and mutually
attuned relationship between infant and parent. These concepts have become the firmly
established underpinnings of the child development field.

Infants and toddlers with developmental disabilities have the same needs as
typical children for primary relationships that support development. Yet, many such
infants and toddlers present special problems that affect their abilities, and the abilities of
their parents, to form strong bonds and relationships. Often young children with
disabilities are unable to elicit typical nurturing response from their parents. Parents are
often unable to "read" their child's cues. Sometimes this is due to the child's inability to
give clear cues. Sometimes it is due to the intense psychological and physical demands
that parents sometimes experience as a result of the role of caring for a baby with a
disability.

After a review of the relevant literature, this investigator could find no studies that
asked early intervention providers to reflect on their beliefs concerning the relative
importance of social/emotional development in their work, or to describe the experience
of addressing those needs in their work with families. It is hoped that the project reported

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here will shed light on those topics. Participants were asked to complete a 22-question survey, in six sections. Those six sections are delineated as follows:

1.   Demographics of participants

2.   Basic beliefs

3.   Assessment of social/emotional development

4.   Intervention in the social/emotional realm

5.   Access to mental health resources for children and families

6.   Support and supervision for practitioners

Demographics of Participants

Nearly two hundred practitioners from a variety of fields responded to the questionnaire. Of those, nine did not sign he informed consent form, and were eliminated from the analysis. Sixty-two did not complete the majority of the questionnaire and they, too, were eliminated. The final sample was comprised of 136 participants from a variety of disciplines (Table 1). More than half identified themselves as teachers or special education teachers with specific expertise.

The education level of participants was higher than expected. Only 2% had not completed college, and 22.1% had completed a Bachelor's degree. Fully two thirds of participants had attained a Master's degree, and an additional 7.4% achieved a doctoral degree (Table 2). Experience ranged from one to forty years, and the median was 16 years.

Participants were asked about the setting in which they currently work   (Table 3). 7.4% responded that they work at a Regional Center. Regional Centers are private non-

profit agencies that receive funds directly from the State Department of Social Services. Staff at Regional Centers include multidisciplinary team members comprised of case managers, intake workers, program directors, normally a pediatrician, and sometimes psychologists and physical, occupational or speech therapists. Forty-one and nine tenths of participants responded that they work for other non-profit agencies, and 19% were in private practice. Forty-nine percent responded "other" and unfortunately, there was no follow-up question asked, so the data on this parameter are incomplete.

Perceptions of Programs' Espoused Beliefs

Participants overwhelmingly agreed with the statement, "Early Start programs I have worked in consider the development of infants and toddlers to depend upon social and emotional development." Ninety-one and four tenths percent of those responding agreed or strongly agreed (Table 4).

Similarly, the overwhelming majority agreed with the statement, "Early Start programs I have worked in consider to development to be rooted in the child's primary relationships." The level of agreement was 89.7% (Table 5).

Assessment

Identification of children with atypical social/emotional development requires assessment. Participants were asked if their programs assess social/emotional development (Table 6); 92.3% of those responding strongly agreed or agreed that their programs do assess social/emotional relationships. While 92.3% had responded positively to the question of whether their programs assess social emotional development, when asked if programs assess parent/child relationships, the numbers decline (Table 6). Seventy-nine and three tenths percent agreed or strongly agreed (Table 7).

Participants named thirty-three assessment tools used in their programs (Table 8). The most frequently named was the Ages and Stages Questionnaire (ASQ), followed by the Ages and Stages Questionnaire Social Emotional (ASQ-SE, the Bayley Infant Neurodevelopment Screener (BINS), the Battell Developmental Screener, and the Infant Toddler Developmental Assessment (IDA).

Interventions

Participants were asked about the statement "Early Start programs I have worked in require providers in my discipline to provide interventions for social/emotional development (Table 9)." Seventy-three percent of those answering the question agreed or strongly agreed that providers in their discipline are required to address social/emotional concerns.

Participants were then given a list of thirteen possible intervention strategies for addressing social/emotional development (Table 10). They were asked to check strategies that they have used.

The most frequently checked items were "modeling appropriate adult/child relationships" (81.6 %), "teaching parents strategies to manage children's behavior" (81.6%), and "assisting parents to become more aware of and responsive to children's cues" (79.4%); 77.2% checked "assisting parents to become more attuned to their children's social and emotional needs." The item "discussing the ways in which a child's disability impacts social/emotional development" received a rating of 75.7%. Making referrals were checked between 62% and 71%. The most likely referrals were to a parent support group (70.6%), followed by referral to a mental health professional (68.4%) and

referral to a parent education class or group (62.5%); 53.7% reported "discussing concerns with a supervisor."

The item checked the least number of times was "providing relationship-based dyadic therapy (22.8%)." This intervention requires special training, and is normally provided by a mental health professional. Unfortunately, there is no way of knowing whether those who did not check items had looked at the question and thought they had not used the intervention, or whether they had simply skipped the question. Therefore, these data do not represent the entire sample accurately.

Mental Health Services

Participants were asked about available mental health resources for families, and 53% of those answering the question indicated that programs they had worked in "always" or "sometimes" employed a mental health consultant. Twenty-three and nine tenths percent had rarely been in programs that employed a mental health specialist, and 16.9% replied their programs "never" employed a mental health specialist (Table 11).

Participants were asked if programs they had worked in made referrals to outside mental health resources (Table 12). Thirty-five percent of those responding said that programs they had worked in "always" made mental health resources available by referral to outside agencies. Thirty-six percent stated that such referrals were "sometimes" available, while 8.5% were "uncertain" whether mental health referrals were made available. Fifteen and four tenths percent said that mental health referrals were "rarely" available, and 4.3% responded that they were "never" available.

Supervision and Consultation

Several questions were asked of program staff members concerning the regularity and type of supervision they received. One question was directed toward private practitioners, asking if they received consultation. The first question was the most general: "Do programs provide individual supervision to assist staff members to reflect on and discuss their work with children and families?" (Table 13) Thirty-four percent strongly agreed that they received such supervision, while 39% responded that they agreed, with 5% indicating that they were uncertain. Twenty-two percent disagreed or strongly disagreed that programs provided individual supervision to discuss families.

Nearly all of those in private practice indicated that they always or sometimes discuss their concerns about families with a colleague or consultant. Sixty-five and nine tenths percent responded that they always received consultation, 30.7% indicated that they sometimes received consultation, and only 3.4% indicated that they rarely or never consulted with a colleague or consultant (Table 14).

Participants were also asked if they received group supervision or case conferences to reflect on and discuss their work with individual infants, toddlers, and their caregivers. (Table 15). The question was phrased in this fashion to differentiate group supervision from staff meetings that primarily address administrative concerns. Sixty-nine and six-tenths percent strongly agreed or agreed that they received group supervision, 18.8% disagreed or strongly disagreed that they received group supervision or attended case conferences for the purpose of assisting staff to reflect on work with individual infants, toddlers, and their caregivers.

Participants were then asked a series of questions designed to elicit more information about the parameters and the purpose and content of the individual supervision received. "Regularity" of supervision was included in each of these questions. The first parameter was "progress of families" (Table 16). Fifty-eight and eight-tenths of participants agreed or strongly agreed that progress of families was a subject of individual supervision. Eight and eight tenths percent were uncertain, 22.8% disagreed, and 9.6 strongly disagreed.

Next, participants were asked to rate their level of agreement with the statement, "Early Start programs I have worked in provide regularly scheduled supervision that encourages me to discuss the feelings of families I work with." (Table17). Seventy-three percent agreed or strongly agreed with this statement, 6.3% were uncertain, 23.2% disagreed, and 8% strongly disagreed.

In the final question concerning the content of supervision, participants were asked if they received regularly scheduled individual supervision that encouraged reflection on the providers' own feelings regarding families (Table 18). Only 15.9% strongly agreed with this statement, 34.5% agreed, and 12.4% were uncertain. Twenty-eight and three tenths percent disagreed, and 8.8% strongly disagreed. Finally, participants were asked from whom they receive individual supervision. They were presented with five options: program director, program coordinator, mental health specialist, and peer in their field, or other (Table 19).

Additional Comments

The final question asked participants for additional comments about social/emotional development and/or child/caregiver relationships. Twenty-five participants responded (Table 20).

Summary

One hundred thirty-six Early Start providers completed the questionnaire regarding their experiences working with infants and toddlers with developmental disabilities and with their families. Implications of the findings of this study will be explored in the following chapter.

CHAPTER V

DISCUSSION

The purpose of this study was to examine the ways in which California Early Start service providers address the social and emotional development of infants and toddlers. The study was undertaken with the knowledge that working with families of young children, and particularly young children with special needs, requires a great many resources. The service provider must be knowledgeable about infant and toddler development; she or he must be able to be sensitive to the needs of both parents and children, and must have the tools to effectively assess and intervene with families. The situations that early intervention providers encounter on a daily basis are complex and fraught with emotion. Finally, in order to successfully navigate through and understand the real and difficult struggles of families, and to cope with the thoughts and feelings evoked, providers must have the strong, consistent support of the programs for which they work.

This researcher came to the topic of the present study as a result of many years' experience in the California Early Start program. That, of course, led to some preconceptions and biases. The impression left after a dozen years providing services was that the social and emotional development of infants and toddlers in Early Start (and one would guess, in many Part C programs throughout the country) is attended to only incidentally, and the emotional experience of providers is often not attended to at all. It is

also the experience of the investigator that parent-child relationships are often side-stepped for several possible reasons: concern that parent-child relationships are not within the province of Part C; worry that addressing intimate relationships is intrusive; and concern about retaining objectivity. The result, however, is that parental needs often remain unmet.

The present study used an investigator-generated questionnaire containing 20 multiple-choice questions, and one open-ended question. Participants were direct providers of services in the California Early Start Program, the organization that administers Part C of the Individuals with Disabilities Education Act (IDEA Part C) for the state of California.   Five areas were investigated: beliefs about social/emotional development; the process of assessment of social/emotional development; strategies for intervention; availability of mental health resources for parents and children; and the supervision offered at participants' programs.

Beliefs about Social/Emotional Development

Participants in this study overwhelmingly believed that programs they have worked in consider social/emotional development to be crucial to all other areas of development and that social/emotional development is dependent upon the strength and quality of the child's relationship with his or her parent(s). The strength of these findings was impressive. It demonstrates a consistent program-wide philosophy that social/emotional development and parent/child relationships are key to overall development.

Further, the exceptionally high rate of affirmative responses suggest that front line workers have enthusiasm for assessment and intervention for social and emotional

development, and for parent-child relationships. This impression is borne out by the responses to later questions concerning interventions and by additional comments made by participants.

The limits of a survey become known in these early questions, and in later sections of the survey as well. More information about both programs' and individuals' philosophies would be better gleaned from combining a survey with a more open-ended format (i.e., interviews or discussion groups). The necessity to keep the survey short and not burdensome for participants resulted in asking questions that may have unintentionally elicited only affirmative responses.

To be more thorough, additional questions about the role of other influences on development (e.g., temperament, cognitive ability, physical limitations, etc.) might have been included. A further investigation to reveal more depth concerning beliefs on both programmatic and individual levels is warranted.

Assessment

A large majority of participants agreed or strongly agreed that their programs assess both social/emotional development (78.6%) and parent/child relationships (79.3%). This gives confirmation to participants' beliefs that their programs consider these areas to be important in terms of assessment, and implicitly, of intervention.

Participants were given a checklist containing ten assessment tools that the researcher believed are commonly used assessments and screening tools in Early Start programs. They were asked to check all tools that were used in programs in which they had worked. They were also asked to specify any other tool that had been used for social/emotional assessment.

Table 8 shows the frequencies of response to each item and the percentage of the sample of 136 participants. It is unknown how many of the sample answered this question and how many did not, so the percentages are less meaningful than a comparison of the frequencies among the responses.

Of the ten options given the most often checked was the Ages and Stages Questionnaire (ASQ) (61 participants) followed by the Ages and Stages Questionnaire-Social/Emotional (42 participants). Both are standardized interviews and both are user and parent-friendly. The ASQ contains subscales for social/emotional development, and the ASQ-SE contains only questions concerning social/emotional development.

The next most frequently used was the Bayley Infant Neurodevelopment Screener (BINS). This is a screening tool, based on the Bayley Scales of Infant Development, and was designed for Part C programs. The BINS takes approximately five to ten minutes to administer. It is designed to screen for atypical neurological development and not for social/emotional development per se, or for assessment of parent-child relationships.

The Infant Toddler Social Emotional Rating Scale (ITSEA) was checked by 28 participants, and the Brief Infant Toddler Emotional Rating Scale (BITSEA) was checked by five. Other than the ASQ-SE, these were the only listed items that were designed specifically to assess social/emotional development. One participant listed the Temperament and Atypical Behavior Scale (TABS), another tool designed to assess social and emotional development.   The use of these four tools in at least some programs represents a very positive step toward full assessment of infants and toddlers.

The number and variety of assessment tools cited was large. In addition to the ten listed items, participants named thirteen other instruments.

Some of the instruments cited were designed for very specific assessment. For example, three of the named items (CHAT, M-CHAT, and AIEP) specifically screen for autism. Those screenings address social/emotional development on some parameters, but are designed purely as a first screening to identify children who warrant further evaluation for autistic spectrum disorders.

One named instrument (the Oregon) is designed to assess visually impaired children. Another (the Rosetti) is a speech and language assessment, though as one participant added, "there is a social/emotional component at the end." The Peabody, which has a language scale and a motor scale, was cited once. This assessment does not directly assess social/emotional development or primary relationships, although language is often an indicator of social skills and emotional health.

The other instruments noted are general assessment tools that include social/emotional assessment along with the other domains required by Part C and Early Start: gross and fine motor, cognitive, language, and adaptive /self-help skills. The purpose of these assessments is to comply with state and federal regulations and to develop and track goals set in the Individual Family Service Plan. Many, such as the Hawaii Early Learning Profile (cited by 17 participants) and the Carolina Curriculum were designed to be curriculum tools rather than assessments.

It would be worthwhile to examine each of these assessment tools, focusing on the social/emotional sections to ascertain how they frame social and emotional development. What questions are asked, what behaviors observed? It would also be valuable to closely examine the format of each instrument. There are assessment tools that are highly structured, and some that are based on observation. Some are based on

parent report. Some are designed for home settings. Some have strict qualification

requirements, and some are designed to be administered by any childcare worker or home

visitor. A close examination of the many assessment tools cited would be a helpful step

in revealing which tools are potentially the most useful for assessing and describing

social/emotional development and parent-child relationships.

In summary, wide varieties of tools are used to assess social/emotional

development. Very few are specifically designed for that purpose, and those are

infrequently used compared to curriculum-focused general developmental assessments.

Yet, providers are convinced of the benefit of social/emotional assessment, and utilize a

variety of tools to meet that end.

In this researcher's experience, many contracted providers do not have a

background in social/emotional development or in infant mental health. Therefore, the

impression was that providers with specific training in another discipline do not assess or

address social/emotional development. However, if the widespread philosophy is that

social/emotional development and parent-child interactions are the foundation of

development, ideally every provider would attend to that foundation. While this format

and resources of this study did not permit extensive investigation into this area, one

pertinent question was asked: Did providers feel that professionals within their discipline

were required to assess social/emotional development? Much to the researcher's surprise,

70.4% of responders agreed or strongly agreed that this is a requirement for professionals

in their field. Future investigations may want to examine how providers in various fields

both assess social/emotional relationships and parent-child interaction, and how those

assessments inform their interventions.

Interventions

As in the question concerning assessment tool used, there was no way to knowing how many participants responded to the question concerning strategies for intervention. This question was also a checklist with the directions to "check all that applied." (Table 10) Thus, the raw frequencies of responses may be more useful than percentages, since the number of respondents is unknown. Providers utilized a variety of strategies to intervene in social/emotional development. The following lists interventions used from most to least:

1. Modeling appropriate adult/child relationships (111)
2. Teaching parents strategies to manage child's behavior (111)
3. Assisting parents to become more aware and responsive to child's cues (108)
4. Assisting parents to become more attuned to child's social/emotional needs (105)
5. Discussing the impact of child's disability on social/emotional development (103)
6. Giving parents educational materials regarding social/emotional development (101)
7. Making a referral to a parent support group (96)
8. Making a referral to a mental health professional (93)
9. Making a referral to a parent education class or group (85)
10. Exploring parent's thoughts and feelings (78)
11. Discussing my concerns with my supervisor (73)
12. Providing relationship-based dyadic therapy (31)

The highest ratings (1 and 2)) were for educational strategies. Next, (3-6) were discussions likely directed by the provider. The next lower category was referrals (7-9). The lowest rated items (10-12) address personal thoughts and feelings.

The hierarchy of responses is not surprising. More than half of the participants were teachers. One would expect that they would be most comfortable with educational and directive strategies. That type of intervention might well be effective in terms of changing behaviors of both parents and children. However, one wonders if more attention to parents' experiences and their specific points of view might result in a deeper understanding of social/emotional developments.

Referrals are also an appropriate intervention. It is interesting that referrals to mental health professionals and referral to support groups ranked higher than referral for parent education. It is thought that parent education is one of the least effective interventions (Mahoney & Bella, 1998). One might hypothesize that referrals might be more difficult for providers than educational interventions in that there is an implication that the parent needs more help than the provider can offer. However, it may still be a more comfortable option than exploring the thoughts and feelings of either the provider or the parent.

It is unfortunate, though not surprising that discussing concerns with a supervisor is nearly at the bottom of the list. As Gilkerson (2005), Heffron (2003), and others have pointed out, relationships in early interventions contain parallel processes. The relationship between supervisor and practitioner affects the relationship between practitioner and parent, which in turn affects the relationship between parent and child. If the final goal is a warm, attuned, consistent, responsive relationship between parent and child, the process must begin at the program level. If providers do not feel comfortable talking to supervisors about the difficult and emotionally challenging work around

social/emotional relationships, one worries that discomfort will travel down the chain to the parent-child relationship.

The final option, providing relationship-based dyadic therapy, is a therapeutic modality used by mental health professionals with specific training. It was included here because it has been shown to be a particularly effective catalyst for change in parent-child relationships and social/emotional development (Arnstein-Kerslake, Knapp, & Merchant, *2005).*

The findings on intervention also bring to mind the work of McBride and Peterson (1997). Their study – the only one of its kind that was uncovered in this research –was an observational study of early intervention providers at work. McBride and Peterson worked in collaboration with a group of home visitors to observe and describe the nature of their interventions with infants and toddlers with developmental delays and their parents. The interventions were videotaped and coded by trained raters. The raters found that a great majority of interventions consisted of play between the provider and child. The providers vehemently disagreed with the raters, believing that they were "modeling" activities for the parents. The investigators also found that many interventions were directive, which again, brought strong disagreement from the providers. The investigators looked again at the videos alongside the providers, and in fact did change some of the ratings as a result. McBride noted that modeling an activity or strategy requires that the provider tell the parent clearly that the purpose of the intervention is to teach the parent. She also noted that directive teaching of both parents and children is less effective than experiential learning.

Given McBride's experience, it is reasonable to suppose that providers' views of their interventions might be quite different from the views of a trained observer. Further investigation into strategies used by providers is warranted. Observational studies building on the work of McBride and Peterson - and perhaps avoiding the pitfalls those researchers encountered - might shed more light on what providers actually do in their interactions with babies and their parents.

Mental Health Services

Two questions asked about mental health services for children and families. First, the question was asked how frequently participants had worked in agencies with a mental health consultant on staff (Table 11). This has been an ongoing recommendation by Zero to Three, and was cited as a great benefit in the Illinois program referenced earlier (Gilkerson & Kobel, 2005).

Fifty-three percent of those responding to that question replied that programs they had worked in always or sometimes employed a mental health consultant. Thus, over half of the programs in this sample had access to a mental health professional on their staffs. This is certainly a great step toward integrating mental health with early intervention.

The role of a staff mental health consultant was not examined. Such a consultant may have a variety of roles: problem-solving with staff, addressing staff's emotional responses and relationships to families, staff training, having joint visits with providers and families, or engaging in treatment with children and/or caregivers.

On the other end of the spectrum, 23.9% of respondents stated they had rarely worked in programs that had a mental health consultant on staff, and 16.9% replied that

they never had had such a person employed by their agency. In this researcher's opinion, this gap must be filled if early intervention programs are to successfully address the social/emotional needs of young children.

Most teachers and other professionals were trained to work with children, not with parents. Yet they all have a close-up view of relationships as they happen. It is this writer's experience that many providers, much as they believe that social/emotional development must be addressed, feel ill-equipped to deal with the highly charged issues of parent/child relationships and mental health in the families they serve.

The second question concerned the frequency of referrals to outside mental health resources (Table 12). This is slightly different from the question relating to referrals in the intervention section above. That question addressed the practice of the individual provider; this one addressed providers' experience of programs' practices, and by implication, their policies, and philosophies.

Seventy-one percent of respondents said that their programs always or sometimes made referrals for mental health, compared to 68.4% who said they personally make mental health referrals. Eight and five ten tenths percent said that mental health referrals were rarely made, and 4.3% responded that such referrals were never made.

It is encouraging that a generous majority makes referrals to mental health resources. Again, this is a step toward integrating early intervention and mental health. Nonetheless, it is concerning that, 12.8% felt that their programs either lacked the resources to make referrals, or have not yet begun to understand the help that such referrals could be to struggling families.

Supervision

Part C early intervention services are based on an educational model. The bill, after all, is called the Individuals with Disabilities Education Act. As this study exemplifies, a large portion of those who provide services in Part C programs identify themselves as teachers or educators.

Classroom teachers are usually supervised by the principals of their schools, and supervision is generally confined to administrative matters. When individual teachers are called to the principal's office for an individual meeting, it is usually for the same reason students are called – they're "in trouble."

Supervision as it is known in the mental health field is entirely foreign to the field of education. Clinical supervision relies on a relationship between supervisor and supervisee that creates an environment in which the experience of being with clients can becomes the topic of interest. That experience includes the clinician's thoughts, feelings, and responses to the thoughts, feelings, and responses of the client.

Experts in the field of infant development have long recognized that while early intervention professionals are not psychotherapists, they are often confronted with the same realities that psychotherapists and social workers generally hear about but do not actually see. Early intervention service providers frequently encounter depressed, anxious, and more severely mentally ill parents. Often those providers must react to overwhelming circumstances such as substance abuse, domestic violence, child abuse, homelessness, and poverty. Very often an early intervention service provider is the only outsider who is privy to the real circumstances of families' lives.

Yet, many early intervention service providers face these challenges alone. That is why there has been an insistent call from experts in the field for supervision and consultation that is akin to that received by mental health trainees and practitioners. The term "reflective supervision" denotes individual supervisory relationships that exist for the purpose of supporting and mentoring early intervention providers, and of strengthening programs as they serve ever needier families. Zero to Three, one most important scholarly journal in the field of infant development, has been calling for the implementation of reflective supervision in all programs serving young children for the past twenty years.

Providers who work with children with disabilities, as Early Start providers do, have an additional group of challenges. Often parents are overwhelmed with the task of caring for a child who is different or disabled. Frequently, parents of infants and toddlers with developmental and/or medical problems are grieving the child they did not have. This grieving process, just as the process of grieving a death, often includes feelings of guilt, anger, despair, and a loss of a sense that life is fair or that the world makes any sense. With this grief comes a struggle to simply manage the demands of daily life. For parents of an infant or toddler with special needs, those demands are often far greater than the demands of caring for a typical child.

Parents who are resilient have the ability to develop nurturing, loving, and predictable relationships with their babies in spite of their grief. Parents who are less resilient due to their environments or early experiences or temperament are more likely to have difficulty accessing the emotional or physical energy to create the reciprocal, transactional relationships necessary for healthy development.

The teachers and therapists who enter the lives of families with such great need deserve to have a place to process and reflect on their experiences. This researcher's experience has been that individual supervision in EI programs occurs far less often than it should. Supervision that addresses the progress of individual families is even less frequent. Supervision that attends to the emotional life of families is rare. Rarer still is supervision that creates an environment that is a safe place to process the provider's own feelings.

The present study asked California Early Start providers to report on the amount and kind of supervision that programs have provided. The phrasing of this group of four questions makes the results somewhat difficult to interpret. Each begins with the phrase, "Early Start programs I have worked in provide" following a certain type of supervision. For example the first question offers the statement "Early Start programs I have worked in provide individual supervision to assist staff members to reflect on and discuss their individual work with children and families." It does not ask about whether they agree that they have received such supervision. It would have been more useful to phrase the above question as, "I receive individual supervision to assist me… . "

Nonetheless, some trends did emerge. Each question concerning program supervision received between 112 and 116 responses. If one assumes that the same 112-116 participants answered each of the four questions concerning the supervision received in Early Start Programs, (Tables 13, 16, 17, and 18) comparisons can be made among the four questions.

Of those participants, 57.3% answered that programs always or sometimes provide individual supervision to discuss individual work with children and families.

(Table 13).   A smaller number of respondents (49.3%) said that programs provided

individual supervision to discuss families' progress. (Table 16). Fifty-one and five tenths

percent (51.5%) of respondents said that programs have provided individual supervision

that encourages them to reflect on and discuss the feelings of families they work with

(Table 17). In comparison, only 42% said that programs had provided supervision to

encourage providers to discuss and reflect on their own feelings regarding families (Table

18).

One has to wonder what was the content of the supervision "to discuss individual

families" (Table 13), as those numbers are fewer in each of the succeeding, more specific

questions.

One surprising result was that more people said that supervision was always or

sometimes provided in order to discuss families' feelings than to discuss the progress of

families.

The finding that appears most significant is that the percentage of supervision

which addresses providers' feelings is so much less than the percentage of supervision

that addresses work with families in general, families' progress, or families' feelings.

One possible explanation goes again to the truth that Part C is an educational program.

Teachers, as a rule (and likely many other providers in Early Start) have been taught that

objectivity is a virtue, and that one's own feelings can only get in the way of being

objective, and furthermore that "good boundaries" demand distancing oneself from the

strong emotions that families' situations can provoke. It is likely that program managers

and workers alike shy away from raising the issue of providers' emotional responses to

their work. One question that was not asked was whether providers would like to have

more supervision that allowed for reflection on their own experiences and feelings. It would certainly be a good topic of further investigation.

Participants were asked, as well, if programs provided group supervision or case conferences to discuss individual families (Table 15). More than half (57.3%) agreed or strongly agreed that programs offered group supervision.

In summary, it appears that between 42.7% and 57% of participants receive some individual or group supervision. While those numbers are promising, it is true, conversely, that between 43% and 57.3% are either uncertain or do not agree that they receive supervision that is not administrative in nature. It should be a goal of Early Start to ensure that all providers receive some supervision, if for no other reason than to give providers a counterbalance to the solitary nature of their work.

Providers working in private practice were directed away from questions regarding program supervision and were asked instead about consultation with colleagues or a consultant (Table 14). Sixty-five percent responded that they always discuss concerns about families with a colleague or consultant. Another 30.7% said that they sometimes have consultation. This result is stunningly different from the responses by program staff to questions about supervision. It is possible that those in private practice are under fewer constraints than are individuals in programs that have to contend with more administrative constraints. At the same time, it is difficult to compare workers' and private practitioners' results because the questions were framed differently. While providers working for programs were asked about program practices, private practitioners responded to a statement framed in the first person: "I discuss concerns about children and families with whom I work with a consultant or colleague." It is quite likely that

program workers would respond similarly, as "discussing" with a colleague is quite different from receiving supervision.

All participants were asked to identify the person from whom they received supervision (Table 19). Many participants named more than one person as supervisor. Two hundred fourteen discrete answers and fifteen different responses were received. Ninety-one, or 66.9% responded that they received supervision from a program director. Of the 214 different answers, 136 or 63.5% were program directors, coordinators, principals, or others who have administrative responsibility for the program. The remaining 36.5% received supervision from a mental health consultant, a group of colleagues, or a multidisciplinary team. Only further investigation would reveal whether there is a significant difference in the experience of supervision between those who are supervised by those with administrative responsibilities and those who are not.

Providers' additional comments

Twenty-five of the 136 participants (18.4%) responded to the request for additional comments. This is not a great enough to generalize about providers' thoughts about how Early Start addresses social/emotional development.

Nonetheless, the comments deserve to be heard. Twelve participants commented that Early Start does not give enough attention to social/emotional development. A lack of funds for reflective supervision was cited, as was a need for more mental health consultation, and more training for providers. Two other participants expressed frustration that Regional centers do not understand the importance of social/emotional development. One participant noted that her program has reflective facilitation bimonthly at staff meetings to help providers reflect on parent/child relationships in the

families with whom they work. Two other participants shared that their programs had an upcoming training in infant mental health. Two participants' comments were not pertinent to the study. All of the other responses demonstrated strong beliefs about the importance of addressing social/emotional development in Early Start programs. (See Table 20 where all comments are provided.)

Implications of this study to research and scholarly work

There is large body of work regarding assessment and intervention with young children. Much of that work however does not address the needs of the very youngest children. It would be beneficial to begin to explore the similarities and difference between children ages three and older with children under three, with the goal of tailoring programs that address the specific needs of infants and toddlers.

There is also a great need to expand advocacy for inclusion of parent-child intervention in reauthorization of IDEA Part C. Further research demonstrating the key role of early relationships to development might increase an understanding of legislators that "family-focused services" needs to include interventions that support the development of parent-child development and thus of all development throughout the lifespan.

The field needs more research into effective interventions to support the social/emotional development of infants and toddlers with special needs and the needs of their parents. Research into effective EI assessments and intervention strategies designed for parents and their typically developing infants and toddlers should be examined and modified for their applicability to parents and children ages birth to three.

Implications of this study to theoretic framework of early intervention and infant/toddler development

A noted previously, only one other study was discovered that looked at the experience of EI service providers. There has, however, been a good deal of research regarding relationship-based interventions for various vulnerable populations of infants and their families (Gilkerson & Stott, 2005; Goldberg, 1977; Howe, 2006; Mahoney & Bella, 1998; Mahoney, Boyce, et al, 1998); McCollum & Yates, 1994; Zero to Three Policy Center, 2004). The present study demonstrates that providers are aware of the necessity to use the infant-parent dyad as a means to support development.

Additionally, participants in this study demonstrated a need for supervision that addresses the emotional experience of both families and providers. This lends credibility to the extensive literature on reflective practice process (Fenichel, 1997-1998, Shahmoon-Shanok, 1991 & 2006; Fenichel, Eggbeer, & the TASK Advisory Board, 1990; Gilkerson & Stott, 2005, Gilkerson & Cutler, 2005, Gilkerson & Kopel, 2005, Heffron, 2000 & 2005).

Additionally, the recent upsurge of research into neuropsychological development has helped to increase providers' knowledge of early development and the necessity to intervene where development, including social/emotional development may be compromised.

Implications of this study for further research

This study suggests several areas that would benefit by further research:

- Observational study of EI interventions in Part C programs

- In depth examination of EI providers' ideas concerning social/emotional development in infants and toddlers

- Assessment of the needs of program managers regarding barriers to more successful implementation of reflective process

- An assessment of the needs of staff for increased training and supervision

- A needs assessment of parents in regard to facilitation of social emotional development and parent-child relationships

- An examination of assessment tools to identify assessments that are most useful for assessing and describing social/emotional development and parent-child relationships

- An examination of how providers in various disciplines assess and intervene in social/emotional development and parent-child relationship

Implications for social work

Early intervention needs social workers. While educators and medical therapists have awareness that social development and emotional health are necessary for development, their training and education focuses on meeting the needs of individual students or patients. In contrast, social workers are steeped in the understanding that individuals, whether children or adults, live and develop in the context of the family, and that families continue to develop in the context of their communities and cultures. The role of context is nowhere more critical than it is for infants and toddlers with developmental disabilities. In order for those children to flourish, their entire micro- and macro-systems must be supported so that a healthy and nurturing environment can endure, even when the challenges are great.

Social workers have roles to play throughout the EI system. As leaders, they are able to bring a vision of relationship-based services, and reflective practice. As consultants, they have the backgrounds necessary to provide supervision, training, and counsel to staff and management alike. As clinicians, they can tackle the challenging tasks of assessment, and rather than working in discrete domains of development, they can intervene with families to support the growth of mental health. Most important, they can provide the caring and nurturing that both teachers and parents need so that they can nurture the infants and toddlers they care for and love.

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Appendix A

SMITH COLLEGE
School for
Social Work

March 14, 2009

Sarah Muchnick

Dear Sarah,

Your screening page has just arrived. We are now able to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Pearl Soloff, Research Advisor

Appendix B

Survey Monkey

Dear Early Start Provider,

My name is Sarah Muchnick. I am a graduate student at the Smith College School for Social Work and am currently working on an independent research project for my master's thesis.

My topic concerns the experience of service providers in California Early Start. I am interested in learning how the agencies or practices in which you work address the social/emotional development of infants and toddlers with special needs. You will be asked to complete a fifteen item questionnaire.

I am not able to offer monetary compensation for participation. However, participation in this project may benefit you by helping to clarify your professional philosophy and goals, and may raise areas of interest for your future work with children and families. I hope that this research will contribute to knowledge about how the social/emotional needs of infants and toddlers are addressed in California and that it will suggest new directions and strategies.

This is an anonymous survey; no identifying information is being collected.. All data will be kept in a secure location for a period of three years as required by Federal guidelines, and any data stored electronically will be password protected. Should I need the materials beyond the three year period, they will continue to be stored in a secure location and will be destroyed when no longer needed.

Your participation in this study is voluntary. You may refuse to answer any question without penalty. You may withdraw at any time up until the survey is submitted to Survey Monkey for data analysis.

By checking the box below, you are indicating that you have read and that you understand the information above, and that you understand that you may exercise an opportunity to ask me questions via email about this study, your participation your rights, and that you have agreed to participate in this study.

If you have questions about your rights or about any aspect of this study, please email me at smuchnic@smith.edu, or contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at 413-585-7974.

Thank you very much for your participation!

Sincerely,

Sarah E. Muchnick

M.S.W. Candidate

1. By checking the box below, I am indicating that I have read and understand the above and agree to participate in this survey.

◯ Yes

2.

Demographic Information

* 1. I currently provide services to infants and toddlers funded by California Early Start, and receive payment from a Regional Center, or I work with infants and toddlers in Early Start, and am funded by an LEA.

◯ Yes

If you do not provide such services, you must exit this survey

[_____]

2. Primary Field

◯ Education

◯ Speech Therapy

◯ Occupational Therapy

◯ Physical Therapy

◯ Social Work (case management)

◯ Clinical Social Work

◯ Psychology

◯ Psychiatry

◯ Pediatrics (M.D.)

◯ Nursing

◯ Other (please specify)

Other (please specify)

[_____]

3. Level of Education

◯ High School

◯ Some College completed

◯ Bachelor's degree

◯ Master's degree

◯ Doctorate

4. My current place of work is a:

◯ Regional Center

◯ Non-profit agency

◯ Private practice

◯ Other

5. Years of experience working with children 0-3

[   ]

3. Social/Emotional Development in Early Start

Definitions:

California Early Start: A statewide program for infants and toddlers with special needs that receives funding from a California Regional Center.

Program: An agency, clinic, groups practice, or individual practice.

1. Please answer the following questions about the early Start programs you have worked in:

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
Early Start programs I have worked in consider the overall development of infants and toddlers to depend on the child's social and emotional development.	○	○	○	○	○
Early Start programs I have worked in consider development to be rooted in the child's primary relationships	○	○	○	○	○
Early Start programs I have worked in assess parent/child relationships.	○	○	○	○	○
Early Start programs I have worked in assess social/emotional development	○	○	○	○	○

2. Early Start programs I have worked in use the following tools to assess social and emotional development: (Check all that apply)

☐ Ages and Stages Questionaire (ASQ)

☐ ASQ-Social-Emotional (ASQ-SE)

☐ Battelle Developmental Screener

☐ Bayley Infant Neurodevelopment Screener (BINS)

☐ Denver DDST/Denver II

☐ Infant Toddler Symptom Checklist (ITSC) System

☐ Parents Evaluation of Developmental Status (PEDS)

☐ Infant Toddler Developmental Assessment (IDA)

☐ Infant Toddler Social Emotional Rating Scale (ITSEA)

☐ Brief Infant Toddler Social Emotional Rating Scale (BITSEA)

Other (please specify)

[   ]

3. Early Start programs I have worked in require providers in my discipline to provide interventions for social/emotional development

○ Strongly Agree   ○ Agree   ○ Uncertain   ○ Disagree   ○ Strongly Disagree

4. Intervention strategies I have used concerning social/emotional development include: (check all that apply)

- [ ] Modeling appropriate adult/child relationships
- [ ] Teaching parents strategies to manage children's behavior
- [ ] Giving parents educational materials regarding social/emotional development
- [ ] Assisting parents in becoming ore aware of and responsive to children's cues
- [ ] Assisting parents to become more attuned to their children's social and emotional needs
- [ ] Exploring parents' thoughts and feelings that might be impeding successful parent/child relationships
- [ ] Discussing the ways in which a child's disability impacts their social/emotional development
- [ ] Providing relationship-based dyadic therapy
- [ ] Discussing my concerns with a supervisor
- [ ] Making a referral to a mental health professional
- [ ] Making a referral to a parent education class or group
- [ ] Making a referral to a parent support group
- [ ] Other
- [ ] None

5. Early Start programs I have worked in employ a mental health specialist to work with children and families

◯ Always ◯ Sometimes ◯ Uncertain ◯ Rarely ◯ Never

6. Early Start programs I have worked in make mental health resources available by referral to outside agencies.

◯ Always ◯ Sometimes ◯ Uncertain ◯ Rarely ◯ Never

If you work in a group or private practice, please skip to Question 8.

7. Early Start programs I have worked in provide individual supervision for staff in order to assist staff members to reflect on and discuss their work with individual infants, toddlers, and their caregivers.

◯ Always ◯ Sometimes ◯ Uncertain ◯ Rarely ◯ Never

Answer Question 8 only if you work in an indivdual or group practice.

8. I discuss concerns about children and families with whom I work with a consultant or colleague.

◯ Always ◯ Sometimes ◯ Uncertain ◯ Rarely ◯ Never

9. Early Start programs I have worked in provide group supervision or case conferences in order to assist staff members to reflect on and discuss their work with individual infants, toddlers, and their caregivers.

◯ Strongly Agree   ◯ Agree   ◯ Uncertain   ◯ Disagree   ◯ Strongly Disagree

10. Early Start programs I have worked in provide regularly scheduled individual supervision to discuss the progress of families I work with.

◯ Strongly Agree

◯ Agree

◯ Uncertain

◯ Disagree

◯ Strongly Disagree

11. Early Start programs I have have worked in provide regularly scheduled supervision that encourages me to discuss the feelings of the families I work with.

◯ Strongly Agree

◯ Agree

◯ Uncertain

◯ Disagree

◯ Strongly Disagree

12. Early Start program I have worked in provide regularly scheduled individual supervision that encourages me to reflect on my own feelings regarding families.

◯ Strongly Agree

◯ Agree

◯ Uncertain

◯ Disagree

◯ Strongly Disagree

13. I receive individual supervision from the following professionals (check all that apply):

☐ Program Director

☐ Program Coordinator

☐ Mental health specialist

☐ Peer in my field

☐ Other (please specify)

[_____]

14. Please add any additional comments you would like to make regarding social/emotional development and/or child/caregiver relationships among the families you work with.

[_____]

Appendix C

Informed Consent

Dear Early Start Provider,

My name is Sarah Muchnick. I am a graduate student at the Smith College School for Social Work and am currently working on an independent research project for my master's thesis.

My topic concerns the <u>experience of service providers</u> in California Early Start. I am hoping to learn <u>about the sorts of issues that you see in your work with Early Start families</u>. <u>I am particularly interested in learning about the challenges of addressing social/emotional development and mental health concerns in the families you serve.   I also hope to learn about professional support and training that you receive in this often-complex work.</u>

You will be asked to complete a survey requiring <u>20</u> to 30 minutes. <u>At the end, you will have the option of adding additional comments. I will be available to discuss such concerns if you choose to contact me via email at Smuchnic@smith.edu.</u>

<u>I am not able to offer monetary compensation for participation. However,</u> participation in this project may benefit you by helping to clarify your professional philosophy and goals, and may raise areas of interest for <u>your future work with children and families</u>.

<u>I hope that this research will contribute to knowledge about how families in Early Start are served, and that it will suggest new ideas about how to address social/emotional development and the mental health of children with special needs and their families.</u>

This is an anonymous survey; no identifying information is being collected.   If the final project contains any illustrative quotations or vignettes they will be disguised to eliminate any risk of identifying either your or your clients.

All data will be kept in a secure location for a period of three years as required by Federal guidelines, and any data stored electronically will be password protected. Should I need the materials beyond the three-year period, they will continue to be stored in a secure location and will be destroyed when no longer needed.

Your participation in this study is voluntary. You may refuse to answer or skip any question without penalty. You may withdraw at any time up until the survey is submitted to Survey Monkey.

By checking the box in the first question below, you are indicating that you have read and that you understand the information above, and that you understand that you may exercise an opportunity to ask me questions via email about this study, your participation, your rights, and that you have agreed to participate in this study.

If you have questions about your rights or about any aspect of this study, please email me at smuchnic@smith.edu, or contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at 413-585-7974.

Thank you very much for your participation!

Sincerely,

Sarah F. Muchnick
M.S.W. Candidate

Appendix D

Table 1

Primary Fields of Participants

Education	69
Psychology	11
Speech therapy	10
Occupational therapy	10
Social work (case management)	6
Clinical social work	6
Nursing	6
Early Intervention	4
Visual Impairment	4
Child development	3
Early Start Administrator	1
Department of Human Services Infant Support Services	1
Family Resource Center	1
Owner of private practice	1
Deaf/Hard of hearing	1
(Missing)	(1)
Total	136

Table 2

Education Level

	Frequency	Percent	Valid Percent
Some college	3	2.2	2.3
Bachelor's degree	30	22.1	22.1
Master's degree	90	66.2	67.7
Doctorate	10	7.4	7.5
Total	133	97.8	100.0
System		136	100.0

Table 3

Current Place of Work

		Frequency	Percent	Valid Percent
	Regional Center	10	7.4	7.4
	Non-profit agency	57	41.9	42.2
	Private practice	19	14.0	14.1
	Other	49	36.0	36.3
	Total	135	99.3	100.0
Missing	System	1	0.7	
Total		136	100.0	

Table 4

Early Start programs I have worked in consider the overall development of infants
and toddlers to depend on the child's social and emotional development

		Frequency	Percent	Valid Percent
	Strongly agree	55	40.4	47.0
	Agree	52	38.2	44.4
	Uncertain	3	2.2	2.6
	Disagree	7	5.1	6.0
	Total	117	86.0	
	Missing	19	14.0	
	Total	136	100.0	

Table 5

Early Start programs I have worked in consider social/emotional development to be rooted in the child's primary relationships

		Frequency	Percent	Valid Percent
	Strongly agree	55	40.4	47.0
	Agree	52	38.2	44.4
	Uncertain	3	2.2	2.6
	Disagree	7	5.1	6.0
	Total	117	86.0	
Missing	System	19	14.0	100.0

Table 6

Early Start programs I have worked in assess social/emotional development

		Frequency	Percent	Valid Percent
	Strongly agree	50	36.8	43.1
	Agree	42	30.9	36.2
	Uncertain	6	4.4	5.2
	Disagree	17	12.5	14.7
	Strongly disagree	1	0.7	0.9
	Total	116	85.3	100.0
Missing	System	20	14.7	
Total		136	100.0	

Table 7

Early Start programs I have worked in assess adult/child relationships

		Frequency	Percent	Valid Percent
	Strongly agree	50	36.8	43.1
	Agree	42	30.9	36.2
	Uncertain	6	4.4	5.2
	Disagree	17	12.5	14.7
	Strongly disagree	1	0.7	0.9
	Total	116	85.3	100.0
Missing	System	20		
		136	100.0	

Table 8
Assessment Tools Used

	Frequency
Ages & Stages Questionnaire(ASQ)	61
Ages & Stages Questionnaire Social Emotional (ASQ-SE)	42
Bayley Infant Neurodevelopment Screen (BINS)	32
Battelle Developmental Screener	30
Infant Toddler Developmental Assessment	28
Denver DDST/Denver II	19
Hawaii Early Learning Profile (HELP)	17
Infant Toddler Symptom Checklist (ITSC) Checklist	7
Parents Evaluation of Developmental Status	7
Infant Toddler Social/Emotional Rating Scale	5
Bayley Scales of Infant Development (BSID)	5
Early Learning Accomplishment Profile	4
Battelle Developmental Inventory	3
Developmental Assessment of Young Children	3
Michigan Early Intervention Developmental Profile	3
Rosetti Infant Toddler Language Scale	3
Vineland Adaptive Behavior Scale	2
Gesell Developmental Observation	2
Brigance Inventory of Early Development	2
Modified Checklist for Autism in Infants and Toddlers (MCHAT)	2
Checklist for Autism in Infants and Toddlers (CHAT)	1
Assessment, Evaluation and Programming System for Infants and Toddlers (AEPS)	3
AIEP	1
Carolina Curriculum	1
Developmental Profile 3 (DP-3)	1
Mullens Scales of Early Learning	1
Oregon Project for Visually Impaired	1
Peabody	1
Social and Communication Questionnaire	1
Sensory Profile	1
Temperament and Atypical Behavior Scale	1

Table 9

Early Start programs I have worked in require providers in my discipline to provide interventions for social/emotional development

		Frequency	Percent	Valid Percent
	Strongly agree	35	25.7	29.7
	Agree	48	35.3	40.7
	Uncertain	15	11.0	12.7
	Disagree	17	12.5	14.4
	Strongly disagree	3	2.2	2.5
	Total	118	86.5	100.0
Missing		18		
Total		136	100.0	

Table 10

Intervention Strategies

	Frequency
Modeling appropriate adult/child relationships	111
Teaching parents strategies to manage child's behavior	111
Giving parents educational materials	101
Assisting parents in becoming aware of and responsive to child's cues	108
Assisting parents to become more attuned to child's s/e needs	105
Exploring parents' thoughts and feelings	78
Discussing impact of child's disability on social emotional development	103
Providing relationship-based dyadic therapy	31
Discussing my concerns with a supervisor	73
Making a referral to a mental health professional	93
Making a referral to a parent education class or group	85
Making a referral to a parent support group	96

Table 11

Early Start programs I have worked in employ a mental health specialist to work with children and families

		Frequency	Percent	Valid Percent
	Always	28	20.6	23.9
	Sometimes	34	25.0	29.1
	Uncertain	8	5.9	6.8
	Rarely	28	20.0	23.9
	Never	19	14.0	16.2
	Total	117	86.0	100.0
Missing		19	14.0	
Total		136	100.0	

Table 12

Early Start programs I have worked in make mental health resources available by referral

		Frequency	Percent	Valid Percent
	Always	41	30.1	35.0
	Sometimes	43	31.6	36.8
	Uncertain	10	7.4	8.5
	Rarely	18	13.2	15.4
	Never	5	3.7	4.3
	Total	117	86.0	100.0
Missing		19	14.0	
Total		136	100.0	

Table 13

Early Start programs I have worked in provide individual supervision in order to assist staff members to reflect on and discuss their individual work with children and families

		Frequency	Percent	Valid Percent
	Always	41	30.1	35.0
	Sometimes	43	31.6	36.8
	Uncertain	10	7.4	8.5
	Rarely	18	13.2	15.4
	Never	5	3.7	4.3
	Total	117	86.0	100.0
Missing		19	14.0	
Total		136	100.0	

Table 14

I discuss concerns about children and families with whom I work with a consultant or colleague

	Frequency	Percent
Always	58	65.0
Sometimes	27	30.7
Rarely	2	4.2
Never	1	0.1
Total	88	100.0

Table 15

Early Start programs I have worked in provide group supervision or case conferences in order to assist staff members to reflect on and discuss their work with children and families

		Frequency	Percent	Valid Percent
	Strongly agree	38	27.9	33.9
	Agree	40	29.4	35.7
	Uncertain	13	9.6	11.6
	Disagree	18	13.2	16.1
	Strongly disagree	3	2.2	2.7
	Total	112	82.4	100.0
Missing		24	17.6	
Total		136	100.0	

Table 16

Early Start programs I have worked in provide individual supervision to discuss the progress of families I work with

		Frequency	Percent	Valid Percent
	Strongly agree	27	19.9	23.7
	Agree	40	29.4	35.1
	Uncertain	10	7.4	8.8
	Disagree	26	19.1	22.8
	Strongly disagree	11	8.1	9.6
	Total	114	83.8	100.0
Missing		22	16.2	
Total		136	100.0	

Table 17

Early Start programs I have worked in provide individual supervision that
encourages me to discuss the feelings of the families I work with

		Frequency	Percent	Valid Percent
	Strongly agree	23	16.9	20.5
	Agree	47	34.6	42.0
	Uncertain	7	5.1	6.3
	Disagree	26	19.1	23.2
	Strongly disagree	9	6.6	8.0
	Total	112	82.4	100.0
Missing		24	17.6	
Total		136	100.0	

Table 18

Early Start programs I have worked in provide individual supervision that
encourages me to discuss and reflect on my own feelings regarding families

		Frequency	Percent	Valid Percent
	Strongly agree	18	13.2	15.9
	Agree	39	28.7	34.5
	Uncertain	14	10.3	12.4
	Disagree	32	23.5	28.3
	Strongly disagree	10	7.4	8.8
	Total	113	83.1	100.0
Missing		23	16.9	
Total		136	100.0	

Table 19

I receive individual supervision from the following individuals

	Frequency	Percent
Program director	91	66.9
Program coordinator	33	24.3
Mental health specialist	29	21.3
Peer in my field	53	38.9
Principal	4	2.8
Multidisciplinary team	3	2.2
Group of colleagues	3	2.2
Case management supervisor	1	0.7
Classroom manager	1	0.7
Clinical services manager	1	0.7
Early Start Supervisor	1	0.7
President and CEO	1	0.7
Program Administrator	1	0.7
Program supervisor	1	0.7
Supervisor	1	0.7
None		

Table 20

Additional Comments

1. Because I am in private practice I have little or no chance to discuss my feelings about the social interaction of families and my relationship with them. I do network with my friends in Early Start to discuss feelings.
2. Cultural differences have impacted the relationship of parent-child interactions.
3. Early Head Start receives much more training in this area than Early Start. We could use more.
4. Families need more help with parenting classes.
5. I've always advocated and supported reflective practice and support for staff, families and especially the social/emotional development of all.
6. I am often concerned that we don't have highly qualified support in these areas.
7. I feel my agency does not emphasize social/emotional development enough.
8. I have created my agency and this may not be found in other privately owned agencies.
9. I have only worked for one Early Start program, and answered questions from Program Director point of view.
10. I have worked in the same program for 24 years. I have had three supervisors. Two have had opportunities to help us reflect and give us support. I have asked the third one time and time again to do this. She does not see the value in it.
11. The clinic I worked at was OT-based for 0-3. There were no mental health professionals. I would refer families back to Regional Center if there were bigger issues. I would deal with behaviors and help parents/children to the best of my ability with their social/emotional needs/development but the main focus was increasing communication skills. As you know, when we work with parents and children 0-3, we are working with the "whole" child. I always tried to have contact with the other therapists on the case as much as possible. Now I work independently through the Regional Center at the family's home.
12. In our program, reflective facilitation is built in bimonthly for all staff to continue to reflect their work in supporting child/caregiver relationships with the families they work with.
13. It has been my experience that it's the Social Service personnel that lack knowledge of the importance of a child's social/emotional development.
14. It would be great to have enough money to provide supervision to all the staff but with the California economy as it is we are struggling to keep the doors [open]
15. My responses reflect current and previous experience within the past 15 years or so.

16. My work at regional center that is specific for Early Start is evaluation and diagnosis, particularly for children suspected of having autism.
17. Need funding to support including mental health professionals on teams and to require reflective supervision of all direct care staff.
18. Sometimes physical health conditions cause behavior problems, so good medical consultation is important.
19. There are few, if any, parenting classes in local communities (especially in the evenings, with child care) for parents who have infants/toddlers with disabilities or those with IFSP's.
20. These topics are not the main concern of Regional Center but they are at another EI program where I work.
21. This area has a huge impact on the level of progress a child makes during therapy, and is largely unaddressed; a strong disservice to children and families as well as minimizing the value of the financial investment for these critical early intervention services.
22. This has always seemed like a weak area of focus. I always like to address the sensory issues that may possibly be compromising healthy interactions.
23. We also use incidental learning in inclusion toddler school.
24. We are receiving a 3 day infant mental health training which will assist tremendously in this area.
25. We are scheduling an Infant Mental Health training to include more information/tools for use in   Early Start.

Appendix E

SMITH COLLEGE SCHOOL FOR SOCIAL WORK
Dissemination Confirmation 2010

Student's Name: _**Sarah Friedman Muchnick**

- Copy of thesis loaned: May 14, 2010
- NOTE: Upon completion of dissemination, return this form and borrowed thesis ASAP to: Laurie Wyman, Administrative Assistant/Research Sequence in Lilly Hall 218, Smith College School for Social Work, Northampton, MA 01063.
- **REMINDER:** PLEASE DO NOT WRITE ON THESES. THANK YOU!
- "Dissemination of Knowledge" deadline: **Friday, August 6th.**
- Note: Check appropriate box below and complete information requested.

[✓] **COLLOQUIUM/AGENCY PRESENTATION/ *PUBLICATION OF ARTICLE***

Presenter(s): Sarah Friedman Muchnick

Moderator/Agency Director: Cindy Arnstein-Kerslake, Infant Development Association of California

Presented On: Date: _____ Time: _____ Place: _____

IN PRINT "IDA California Newsletter: Prospective publication date: _Quarterly Newsletter June 2010_

Moderator's/Agency Director's Signature & Date: _____ _May 3, 2010_

[ ] **CLASS PRESENTATION**   Instructor:_____

Course # and Title: _____

(Includes Writing For Publications Requirement)

Date of presentation: _____ Time: _____

Instructor's Signature / Date: _____

[ ] **POSTER SESSION** - Date of session: **TBA**

Faculty / Date: _____

[ ] **SECOND READER**

Name of Second Reader: _____

My signature confirms that I have reviewed the above-mentioned student's thesis and met with her/him on:

_____ to share an assessment of it in a brief conference.

Second Reader's Signature / Date: _____

NOTE: If your second reader is NOT on campus, then in lieu of this form it is necessary that your reader confirm the date of conference/meeting in a **brief letter on her/his agency or business letterhead.** Please address and mail letter to: Chair, Research Sequence, Smith College School for Social Work, Northampton, MA 01063.