PROGRAM EVALUATION

Florida Infant & Young Child Mental Health Pilot Project

YEAR 3

FINAL REPORT

July 1, 2000 to June 25, 2003

Submitted to Florida Department of Children & Families
Children's Mental Health
June 27, 2003

Florida State University
Center for Prevention & Early Intervention Policy
Tallahassee, Florida

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Florida's first infant mental health pilot project was supported by the Florida Legislature under the leadership of Senator John McKay in the Senate. In addition, Sue Ross, Bureau Chief for Children's Mental Health and Celeste Putnam, State Mental Health Program Director in the Department of Children and Families, have provided oversight and guidance during the three years of the project. FSU Center for Prevention and Early Intervention Policy and the three pilot sites are grateful for the opportunity to have participated in this pioneering effort.

Florida State University Center for Prevention & Early Intervention Policy
Tallahassee, Florida

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EXECUTIVE SUMMARY

Project Description

This study, conducted by the FSU Center for Prevention and Early Intervention Policy, is an evaluation of a three-year, multi-site, infant mental health pilot, *Florida's Infant and Young Children's Mental Health Statewide Pilot Project.* The pilot project was initially funded in 2000 by the Florida Legislature and implemented in conjunction with Children's Mental Health in the Department of Children and Families (DCF). Three diverse sites were chosen: Miami (a collaborative project between the Dependency Division of the Juvenile Court, Eleventh Judicial Circuit, and the University of Miami's Linda Ray Intervention Center), Sarasota (Child Development Center) and Pensacola (Lakeview Community Mental Health Center). The purpose of the project was to provide a research-based model of dyadic therapy services with a sample of high-risk infants, toddlers and their families during the critical first few years of life in order to promote bonding and attachment, positive interactions, and secure relationships between the child and mother (or primary caregivers). Because children under the age of three are the fastest growing segment of children entering the foster care system, the population targeted for the pilot project were children under the age of three years who were at risk for out-of-home placement due to abuse or neglect or children who had already been placed in foster care but parental rights had not yet been terminated.

Goals and Outcomes

Five goals were addressed in the project with the following outcomes:

Goal 1: To improve parent/caregiver and child interaction and relationships, reduce occurrence or reoccurrence of abuse and neglect, and enhance the child's developmental functioning.

Outcomes. There were four major outcomes related to this goal. First, there was reduction of child abuse and neglect. Reports of abuse/neglect were reduced from 97% of children prior to treatment to 0% of the children completing the pilot project. Secondly, there was reunification with the family or permanent placement for all children completing the pilot who were not in parental custody at the beginning of the project. Thirdly, the health and developmental status of children improved. Following treatment, 58%% of children improved in their developmental functioning. And fourthly, the parent-child relationship functioning improved significantly in all domains for both parents and children. Parents showed an increase in behavioral and emotional responsiveness with their children and a decrease in intrusive behaviors. Children showed an increase in positive affect (emotions) and enthusiasm with their parents. The percentage of caregivers reporting depression reduced from 51% pretreatment to 29% following completion of treatment. Seventy percent (70%) of caregivers reported minimal to no depression after treatment.

Goal 2: To document the components of quality infant mental health interventions and analyze them for replicability, sustainability, effectiveness, and affordability for potential use in a statewide system.

Outcomes. Components of the assessment protocol are recommended for use but will require training and adequate reimbursement. The dyadic therapy model appears to be an effective short-term treatment approach for those dyads who completed their treatment program. Follow-up studies will be needed to determine long-term effectiveness. Engagement/case management/outreach activities provided by the treating therapist within the context of the therapeutic alliance with the parent were considered critical to completion of the treatment program and to the effectiveness of the intervention.

Goal 3: **To identify barriers and solutions for systemic changes in infant mental health.**

Outcomes. Several barriers were identified including lack of reimbursement for "engagement" services, problems with pre- authorization process, inadequate funding for children of "working poor" or children without insurance, and ineligibility of at-risk children for Part C early intervention services. Potential solutions were suggested.

Goal 4: **To develop model infant mental health treatment programs which can be replicated statewide.**

Outcomes. Assessment and treatment strategies used in this pilot project emphasize comprehensive, family-centered, developmentally appropriate intervention that focuses the needs and strengths of the child within home and community settings.

Treatment is provided within the context of the child's primary relationships and focuses on the mom/baby dyad as a unit.

Replication will require increasing awareness and training, as well as collaboration among agencies.

Recommendations:

- Expansion of Medicaid billing (fee for service) is recommended to include "engagement" activities as defined by "pilot" project.
- Expand caps on number of individual/family therapy and In home-on site (ITOS) services for 0-5 population.
- Explore utilization/certification of "pilot" assessment to replace comprehensive assessments for 0-5 and/or create equitable levels of reimbursement for 0-5 in-depth assessment.
- Create an Infant Mental Health Specialist training, credentialing, and supervision program on a statewide basis to develop a cadre of competent therapists for serving this population.

Goal 5: **To build capacity in the infant mental health field, especially in the areas of assessment and direct therapeutic interventions.**

Outcomes. Therapists for the three pilot projects have received training and have gained experience and expertise in assessment and treatment, particularly dyadic therapy. In addition, there has been a substantial increase in training opportunities around the state that have been a spin-off from the pilot project and the community mental health Medicaid policy for children 0-5.

FSU Center for Prevention and Early Intervention has been awarded a Harris Foundation grant for Infant Mental Health, joining only 10 other institutes in the country recognized for excellence in training, thereby helping to create an infrastructure for infant mental health training in Florida.

Policy Implications and Recommendations

Recommendation #1: Intervene early.

Recommendation #2: Prevent or reduce multiple placements of infants and toddlers.

Recommendation #3: Fund Florida's EIP system to a level that will enable them to serve infants and toddlers in the foster care system who are at risk for developmental delays, but not yet delayed enough to meet eligibility criteria.

Recommendation #4: Accept pilot project's assessment protocol for Comprehensive Assessments.

Recommendation #5: Expand Medicaid billing to allow reimbursement of "engagement" activities as defined by pilot project or find other means to compensate for needed "engagement" services.

Recommendation #6: Provide individual psychotherapy and/or psychopharmacological treatment in addition to dyadic treatment for severe maternal mental health and substance abuse problems.

Recommendation #7: Reduce transportation barriers.

Recommendation #8: Promote service integration at the local and state level.

Conclusion

The assessment and treatment strategies used in the infant mental health pilot project were found to be effective in improving parent/child interaction and relationships, eliminating abuse and neglect, and increasing reunification or permanent placements of children in foster care for the 43 parent/child dyads that completed treatment. Although the findings are promising, conclusions about program effectiveness cannot be drawn nor can the findings be generalized to other populations due to small sample size. Long term effectiveness of the project will require follow-up study.

Introduction

A convergence of research indicates that relationships and experiences during the first three years of life are critical to healthy social and emotional development and set the stage for future learning and relationships. Children who experience warm, nurturing and responsive interactions and relationships with primary caregivers early in life development of a sense of security and trust, as well as the ability to manage emotions and function effectively in their environment.

Without this critical attachment relationship, a child may develop serious social emotional problems, fail in school, or have mental health problems. Factors such as abuse or neglect, maternal substance abuse, depression and/or mental illness, domestic violence or other risk factors substantially elevate a child's risk for intergenerational cycles of abuse, neglect, mental illness, and violence. Infants of mothers with serious mental illnesses and substance abuse are at four times greater risk of being removed from their homes during the critical period of development (Wulczyn & Hislop, 2002). Of the approximately one million children under age five in Florida, many are considered at high risk for emotional problems. Of particular concern are the 10,000 children under 6 years of age in the Florida child protection system.

Increasing evidence suggests that the brain's biological reactions to abuse and a lack of critical nurturing, especially in the early years, is the incubator of violence. Many children in foster care miss the "window of opportunity" for maximizing healthy attachment. While placing children in multiple foster homes is detrimental at any age, it can be most damaging during those first few years of life. Dysfunctional interactions can profoundly affect the child's early psychological and neurological development, "hard wiring" dysfunctional behaviors, which are difficult to change (Schore, 2000). Developmental problems are all too common for children in foster care. Speech, language and cognitive problems often co-occur with emotional problems and exposure to violence in young children. The national prevalence of delays reported among foster children ranges from 3% to 58% (Hill, Lakin, Novak, & White, 1987). Newer unpublished data suggest as many as 70% of the children in foster care and protective services are delayed in cognitive, language and social/emotional development.

Promoting healthy attachments and preventing young children from languishing in the foster care system during this critical period can help prevent the next generation of children with social and emotional problems. Interventions that come later in the child's life can help ameliorate the impact of early maternal deprivation, neglect or maltreatment, but they are not likely to completely restore the lost capacity for emotional and behavioral health. Therefore, interventions for high-risk infants provided early in development are the best strategy to prevent future emotional disturbances, intergenerational patterns of abuse and neglect, and tendencies towards violence.

Yet the recent U.S. Surgeon General's Report on Children's Mental Health noted that 10% of children had mental illness but less than 20% of these received services. The lack of mental health interventions for very young children and their families is in part a result of a lack of awareness and understanding of the need for mental health services for infants and toddlers. In addition, there is a lack of trained mental health professionals who have expertise in assessment and treatment approaches that are applicable and effective with this young high-risk population.

The Judicial System and Child Protection System have an opportunity to make a difference in breaking the intergenerational cycle of abuse, neglect, and violence by making linkages between mental health organizations and the court. This project evolved out of the pioneering work of Dr. Joy Osofsky at Louisiana State University Health Sciences Center. Her programs provide comprehensive assessments of children who are in foster care, who have witnessed violence or otherwise been traumatized to detect potentially serious mental health conditions such as clinical depression or traumatic stress disorder while they are still in their earliest stages when treatment is most effective. Dr. Osofsky partnered with Judge Cindy Lederman in Dade County, Florida, to replicate the comprehensive assessments for young children in her Juvenile Dependency Court. This became the basis for Florida's Infant Mental Health Pilot Project.

Overview and Description of Project

The state of Florida recognizes the need for infant mental health services and has created a ground swell of community support throughout the state. Through a collaboration between the Florida Developmental Disabilities Council, the Florida Department of Children & Families, and The Ounce of Prevention Healthy Families Florida, Florida State University Center for Prevention & Early Intervention Policy created a statewide strategic plan for developing a system of mental health services for children under five and their families. This comprehensive view of promoting infant and early childhood mental health addresses all front-line caregivers who may be a part of the life of a young child: parents and extended family, childcare providers, health care providers, home visitors, parent educators, social workers, child protection case workers, police officers, judges, foster parents, and caregivers in the faith-based community.

Despite an increase in awareness of infant mental health, Florida does not have a comprehensive, integrated system of mental health services for young children under age five and their families. Many young children who are at risk for social/emotional or behavioral health problems have to wait until they are older, usually school aged, and their problems more severe before they are identified and receive any mental health intervention services. This report is an evaluation of the 3-year, multi-site, infant mental health pilot project, *Florida's Infant and Young Children's Mental Health Statewide Pilot Project.*

This pilot project was first funded during the 2000 legislative session in order to establish three infant mental health pilot projects in Florida and conduct an annual evaluation of the project. The Florida Legislature appropriated $250,000 each year to the Department of Children and Families for three consecutive years to develop the three pilot programs, train staff, provide the services, and evaluate the projects. The project was first funded for FY 2000-2001, but did not actually begin until January 2001, which was the second half of the fiscal year. The pilot project ended June 25, 2003.

The purpose of this three year, multi-site infant mental health pilot project was to identify and intervene with high-risk infants and toddlers and their families during the critical first few years of life in order to foster secure attachments and promote positive interactions and relationships between the baby and mother or other primary caregivers.

Because children under the age of three are the fastest growing segment of children entering the foster care system (Wulczyn, Harden, & George, 1997), the population targeted for the pilot project were children under the age of three years who were at risk for out-of-home placement due to abuse or neglect or children who had already been placed in foster care but parental rights had not yet been terminated. This population is considered at high-risk for both emotional and behavioral problems due to abuse or neglect, maternal substance abuse, domestic violence and/or mental illness. Children who are at risk for out-of-home placement or in the child protection system are a priority for the Department of Children and Families in the State of Florida, and children under six years of age comprise approximately 40% of the children in protective custody.

Project Goals

The project has five goals:

1. To improve parent/caregiver and child interaction and relationships, reduce occurrence or re-occurrence of abuse and neglect, and enhance the child's developmental functioning. There are three major outcome measures related to this goal:
    - Reduction of child abuse and neglect
    - Reunification or permanent placement
    - Improved health and developmental status for children
2. To document the components of quality infant mental health interventions and analyze them for replicability, sustainability, effectiveness, and affordability for potential use in a statewide system.
3. To identify barriers and solutions for systemic changes in infant mental health such as appropriateness of diagnostic labels and measurement tools, reimbursement possibilities including Medicaid and third party billing, and need for ancillary services.
4. To develop model infant mental health treatment programs which can be replicated statewide.
5. To build capacity in the infant mental health field, especially in the areas of assessment and direct therapeutic interventions.

The activities and outcomes of each goal are reported on the following pages.

Goal 1: To improve parent/caregiver and child interaction and relationships, reduce occurrence or reoccurrence of abuse and neglect, and enhance the child's developmental functioning.

Description of the Intervention Sites

The pilot project was launched in three diverse sites: a dependency court in a culturally and ethnically diverse, densely populated, urban city (Miami); a community mental health program in a rural setting (Pensacola); and a comprehensive early intervention program involved in the first foster care privatization project in the State (Sarasota). These three sites are geographically, socio-economically, and culturally diverse.

- Miami's pilot project is a joint partnership between the 11th Circuit Juvenile Court's dependency division and the Linda Ray Intervention Center at the University of Miami. This pilot site only serves infants and young children who have documented abuse and neglect reports.
- Pensacola's project is part of Lakeview Behavioral Health Center, which is a large community mental health provider for children and adults. During the third year of the pilot, Lakeview Center became the lead agency for district child welfare community-based care programs.
- Sarasota's project is part of the Child Development Center, which is a comprehensive early intervention agency serving children ages 0-5 years. It is also the community-based care program for children ages 0-5 years in Sarasota and DeSoto Counties.

Description of the Intervention

Assessment and Treatment

Dr. Joy Osofsky at the LSU Health Sciences Center's Department of Psychiatry originally developed the assessment and treatment protocols for Project PREVENT in Miami's Dependency Court. These protocols were used as a model for *Florida's Infant and Young Children's Mental Health Statewide Pilot Project* because they were the only known assessment protocols being used systematically in the State for children under 5 years of age and were also being used nationally in similar programs. Variations to the extensive assessment process were made. However, a main component of the assessment process, observations and videotaping of the mother-baby interactions during three distinct situations, (free play, two teaching tasks, and a separation and reunion event), was retained because of its value in assessing the quality of the overall relationship and, more specifically, the attachment relationship.

The following assessment tools were administered pre and post treatment:

- Ages and Stages Questionnaires (ASQ; began using post treatment in year three)
- Beck Depression Inventory-2
- Child Development Center Pediatric Intake (conducted pre-treatment only)
- Parent-Child Relationship Scale and Manual
- Parenting Stress Inventory – Short Form

These evaluation tools were chosen in consideration of variables such as the length and cost of the tools, validity and reliability, usefulness of the data that the tool should yield, intrusiveness, and skill, as well as technology, needed to administer the tool appropriately.

- *Background Information Form* – The background information form was developed by the evaluators based on the information available at each of the sites, as well as a determination of the additional data that was needed to provide a thorough understanding of the infants and families participating in the program. The background form collects information about personal and social development and information, educational background, legal issues, and medical, psychological and abuse conditions, as well as a diagnostic understanding of the dyad in a user-friendly format.

- *Parent-Child Relationship Assessment* – This assessment provides observational data that is then coded to provide a better understanding of the interactions between the caregiver and child during one unstructured and two structured play sessions and a separation and reunion. The observational assessment is a modification of the Crowell assessment paradigm (Crowell & Feldman, 1991). Observations of the parent-child relationship are carried out using two-way mirrors. The coding system is based on the original Crowell measures that were used for research purposes and was modified for this project. The parent domains that are assessed include positive and negative affect, intrusiveness, withdrawn/depressed, irritability/anger, behavioral responsiveness, and emotional responsiveness. The child domains include positive and negative affect, withdrawn/depressed, irritability/anger, noncompliance toward parental instruction, aggression toward parent, enthusiasm, and persistence with task.

  A separation and reunion situation is conducted to provide insight into the attachment relationship. The child is observed when the caregiver leaves the room for up to three minutes. The separation is terminated if the child becomes too upset. When the parent and child are reunited, both the parent and child's emotional responsiveness is measured. Throughout all of the observations, parenting style, discipline methods, and qualitative data about how much the caregiver smiles, looks at, and talks to the child are assessed.

  Observations of parent/child interaction are videotaped and consist of the following structured and unstructured situations:

  - Unstructured Play. This is used to initiate an eight-minute period of child/parent free play.

  - Clean–up. The parent is asked to instruct the child to pick up and put away the toys used during the unstructured play. The parent may assist the child if necessary.

  - Two Tasks. The first task involves completing an activity expected to be developmentally easy for the child according to the child's age. The second task is then designed to be more challenging for the child. The tasks are to be completed by the child with the parent's involvement.

  - Separation/Reunion. This is based on Mary Ainsworth's classic work using separation and reunion episodes in the development of attachment classifications (Ainsworth, et al, 1978). The child's attachment classification was derived from the child's reaction to the mother's leaving and return. A classic pattern for a secure infant is to be upset by the mother's leaving and comforted the mother's return. Insecure children may or may not be upset by the mother's leaving and do not seek proximity or are not comforted by the mother's return. A modified version of the separation-reunion task is used for this project to observe the child's behavior during separation and both the child and mother's behaviors during reunion to provide insight into the parent/child relationship.

- *Child Development Center Pediatric Intake* - This intake form is designed to gather demographic information from the parent as well as information regarding the child's prenatal and birth history, family history, child's health and development, child maltreatment information, etc. The interviewer and caregiver complete the form during the initial session

- *Beck Depression Inventory II* – The BDI-II is a 21-item self-report instrument measuring the presence and severity of reported depressive symptoms in adults and adolescents aged 13 years and older. Maternal depression is associated with many risk factors present in this population.

- *Parenting Stress Index – Short Form* – The PSI is a 36-item self-scoring questionnaire/profile. It yields a Total Stress score from three subscales: parental distress, parent-child dysfunctional interaction, and difficult child. It also has a validity subscale to determine the amount of response bias: defensive responding. The PSI is designed to be helpful in early identification of dysfunctional parent-child systems, levels of parental stress, intervention and treatment planning in high stress areas, family functioning and parenting skills, and assessment of child-abuse risk.

- *Ages and Stages Questionnaire* (ASQ-II): A Parent-Completed, Child Monitoring System, Second Edition -- The ASQ is a reliable method for screening infants and young children for developmental delays during the first five years of life. Parents or caregivers complete the illustrated, 30-item questionnaire that covers the domains of communication, gross motor, fine motor, problem solving, and personal-social development.

- *Posttest interview and satisfaction survey:* This interview was developed for the project in Year 2 to capture the parent's satisfaction and subjective opinion of program effectiveness. It is administered at post testing after 25 sessions.

Table 1. Assessment Tools

Area of Assessment	Desired Outcomes	Tools	Method	Timeframe
Demographic	Learn history of clients; gain understanding of child's family context, community and culture	1. Pediatric Intake Form 2. Background History Form	Interview	Visit #1
Child Development	Identify delays in development and make appropriate referrals as needed	Ages and Stages Questionnaire	Parent interview	Visit #1 & Visit # 25 or as useful.
Parent/Child Relationship	Improve the parent–child interaction	Modified Crowell Assessment	Observation of free play, two tasks, separation and reunion	Visit #1 & #25
Maternal Depression	Identify and refer for treatment	Revised BDI (BECK) 2	Interview with mom	Visit #2
Parental Stress	Support and encourage coping skills	PSI – Short Form	Parent questionnaire	Visit #2, & Visit #25
Cost and time breakdown	Assess scope and cost of services	New Cost/time Data Form	Therapist fills out	Monthly
Parent satisfaction	Learn parent's opinion of program effectiveness	Parent interview form with open ended questions	Parent interview	Midway and final Visit #25

An individualized treatment program was developed based on the findings from the assessment, although all plans included home visits to the mother (or caregiver) and 25 sessions of dyadic therapy. The therapeutic work incorporated a broad range of techniques to enhance the mother's awareness and responsiveness to her child's needs, modeled appropriate parenting behavior, promoted empathy, and examined underlying concerns from the mother's own upbringing that may influence her interactions with her child. The treatment plan was individualized and could also include referral for other services, such as occupational therapy or speech therapy, or to other community based agencies for additional services as needed. Project therapists needed to remain in close communication with the child's foster care caseworker.

Treatment - The therapeutic work incorporates a broad range of techniques to enhance the mother's awareness and responsiveness to her child's needs, models appropriate parenting behavior, promotes empathy, offers parental guidance, and examines underlying issues from the mother's own childhood that may influence her interactions with her child. The treatment plan may also include referral for other services, such as occupational therapy or speech therapy, or to other community based agencies for additional services as needed. Communication between the local Department of Children and Families (DCF) Family Service workers who are involved with the cases and pilot staff is considered critical to providing effective intervention. Ideally, the pilot project therapists work in close collaboration with the children's caseworkers.

Because of limited funding and the intensity of services, each pilot is small, with only 10 – 15 families on a caseload at any one time at each pilot site. Due to the difficulties in parental cooperation and compliance in this high-risk population, families required and received personalized attention from project staff. Engagement, case management and outreach activities were critical components of this project.

Engagement - Children who have been abused and/or neglected or are at risk for abuse often have parents who are difficult to engage and sometimes even more difficult to sustain in a therapeutic process over time. Many of the parents have problems with their own mental health, substance abuse and/or domestic violence, which often go untreated and interfere with parenting. All three sites found it necessary to provide extensive engagement efforts to involve and work with the parents of this young at-risk population.

Families with older, school-aged children have teachers and other adults in their lives who can influence and help assure that a child who needs mental health assessment and treatment obtains those services. This is not true for most children under 5 years of age, especially infants and toddlers, and supports the importance of engagement, case management and outreach activities so that these children do not remain invisible to the mental health system and end up having to wait until they are older and their problems more severe before they receive help.

Description of the Individuals Who Began Treatment: Family Demographics

One hundred and five (105) infant/caregiver dyads were referred into the program for the Florida Infant Mental Health Pilot Program. Of these, 84 completed the pre-treatment assessment. Forty-three (43) completed treatment, 42 were noncompliant or had other issues so treatment was discontinued, and 20 remain in progress.

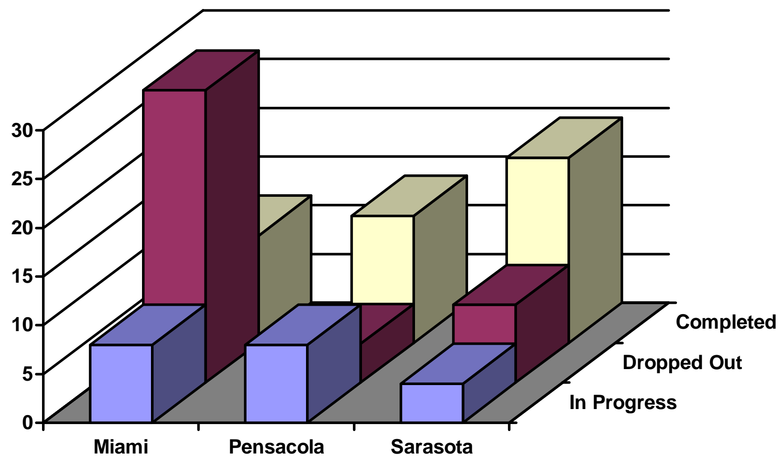
Some of the reasons provided for why treatment was not completed were as follows:

- The child's home was located too far from the treatment center
- The whereabouts of the child's mother is unknown; the child is living with the grandparents
- The Department of Child and Families (DCF) case was closed and, therefore, the family did not have to complete treatment.
- DCF caseworkers did not provide the extra support and pressure needed to keep the client compliant with the therapy appointments.
- The mother was incarcerated.
- Mother's mental health issues, especially when untreated, interfered with completion of treatment.

Many families are reluctant to obtain mental health treatment because of the stigma associated with psychological problems. Families who risk losing custody of their children are even more reluctant to provide information that would suggest inability to parent (drug history, mental health, history of violence). In addition to the resistance that may normally occur related to seeking mental health treatment, other risk factors contributed to noncompliance including maternal mental illness and dysfunction in the families. Depressed mothers often do not, and cannot, initiate services. In one pilot site, home visits were made to provide outreach for these mothers. Lack of transportation was a significant barrier to treatment. Many of these families had to travel a great distance, often on public transportation, and within extremely limited finances. Therefore, either providing better means of transportation or making treatment as accessible as possible to families is very likely to increase compliance.

Miami had a total of 49 cases, Pensacola had 25, and Sarasota served 31 dyads, for a total of 105. The following chart summarizes this information and also includes a review of treatment progress by site. Because some cases were pretested but never entered the treatment phase of the program and others dropped out before completing their treatment program, the data in this final report includes information on 84 infant-parent dyads for pre-treatment assessment, and 43 dyads for post-treatment assessment.

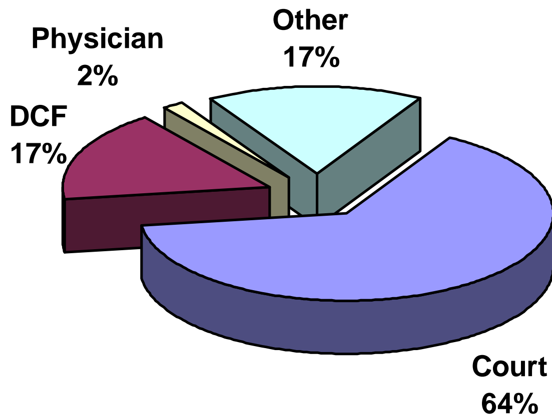
Figure 1. Number of Individuals Completing Treatment Across Sites



Referral Sources for Children Included in the Pilot Infant Mental Health Project

The Department of Children and Families or the Dependency Court referred the majority of dyads in the pilot study.

Figure 2. Referral Sources



The Court referred 100% of children in Miami for services. The Department of Children and Families in Pensacola referred sixty-four percent (64%) of children for services, with the others being referred by the court, doctors, and others. The Sarasota referrals were typically from the Department of Children and Families (68%), with others being voluntary or referred by the Child Development Center , or First Step Program, which is a drug abuse program.

Demographics of Children Entering the Pilot Project

(Based on the 84 individuals who completed the pre-treatment assessment)

Age

Across all three pilot sites, young children ages two to forty-two months were included in the project. The mean age across all sites was 19 months. A breakdown of ages across the three sites is as follows:

Table 2. Age in Months of Children at the Time of Evaluation Across Pilot Sites

	Mean	Median	Mode
Miami	17.6	14.0	12.0
Pensacola	20.7	19.0	14.0
Sarasota	18.5	16.0	23.0

Gender

Across all sites, more boys were included in the study than girls (55% vs. 45%), except for in Sarasota where females outnumbered males.

Table 3. Gender of Children Across Pilot Sites

	Males (Percentage)	Females (Percentage)	Total Children at Site (N)
Miami	65%	35%	34
Pensacola	61%	39%	23
Sarasota	37%	63%	27

Race

The ethnic diversity across the three sites was marked. Forty-two (42.5%) of clients were African-American, 29.3% were Caucasian, 13.4% were Hispanic, 11.0% were biracial, and 4.9% classified themselves as other.

The racial diversity changed when each site was considered individually. Miami's clients were predominantly African-American and Hispanic, Pensacola was equally mixed between Caucasian and African-American and Sarasota was divided mostly by Caucasian and Biracial individuals.

Table 4. Race of Children in the Pilot Study

	Caucasian	African-American	Hispanic	Biracial	Other
Miami	2.9%	64.7%	26.5%	0.0%	5.9%
Pensacola	47.8%	47.8%	0.0%	4.3%	0.0%
Sarasota	48%	4.0%	8.0%	32.0%	8.0%
Total Across Sites	29.3%	42.5%	13.4%	11.0%	4.9%

Type of Abuse

Overall, 97% of children completing the study had been abused or neglected. The court system or the Department of Children and Families referred most of the children, so the high abuse and neglect rate is not surprising. The majority of individuals who abused and/or neglected the children were the mothers (62%), with fathers being the second most likely (15%) to commit this offense. It is not surprising, therefore, that according to initial interview, 78% of the caregivers treated neglect or abuse as if nothing bad had happened to the child. That is, many of the parents were likely in denial that they had either abused or neglected their child/children.

Table 5. Type of Abuse/Neglect Suffered by Children Prior to Beginning the Study

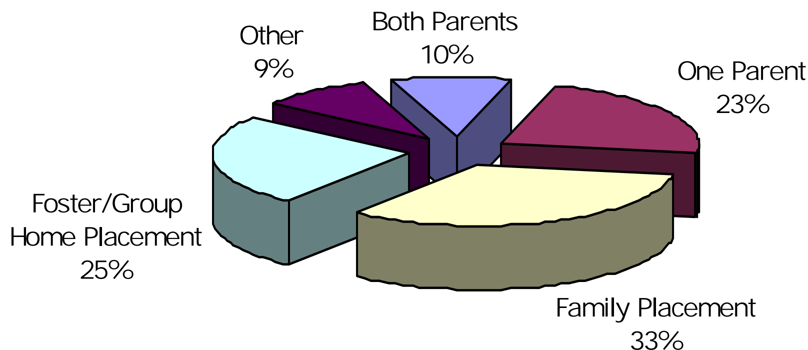
Type of Abuse/Neglect	
Neglect	97%
Threatened Harm/Failure to Protect	7%
Physical Abuse	7%
Substance Abuse	15%
Mental Abuse	4%

Note: Some children had multiple counts of abuse/neglect so the percentages do not equal 100.

Child's Living Situation at the Beginning of Therapy

Across all sites, approximately one-third of children were living with one or both parents, with another third living with other relatives. The therapists rated 29% of homes as "chaotic." Although the majority of the children are now living with a relative, most of the children across sites had been placed out of the home (73%), with 39% of children being placed out of the home two or more times. This was not the first contact with the "system" in 57% of cases. Given that the average age of the children in the pilot was 19 months, many of these infants and toddlers had already experienced multiple placements.

Figure 3. Child's Placement at the Beginning of Therapy



Medical and Health Care

The average birth weight of children in the study was 7.17 pounds, although 26% of the infants were born prematurely. Intensive care intervention was required in 17% of cases. Twenty-one (21%) percent suffered from jaundice as an infant.

Seventeen percent (17%) of the children in the pilot study were described as having "serious medical problems" (i.e., heart problems, bronchitis, asthma). It was reported that 97% of the children got regular health care, and all but two children were up to date on immunizations. Twenty-four percent of the children had complications at birth.

The pregnancies were complicated by the fact that 20% of mothers reported using drugs or alcohol during the pregnancy, with Sarasota the highest (46%). This difference may be related to the way the question was asked in Sarasota (i.e., "What kind of drugs did you use doing pregnancy?" versus "Did you use drugs during pregnancy?"), and they also reported that they looked at birth records from hospitals where this information is documented, especially drug use. It should be noted, however, that self-report data is generally very poor for prenatal alcohol/drug use, especially when the child is in the foster care system. Parents fear, and rightfully so, that the information will be used against them in getting their children back. National data reports 69-70% of children in foster care have been exposed to alcohol/drugs in utero.

A review of drugs indicated that six used cocaine, three used crack, three used alcohol extensively, and six smoked marijuana (some mothers used more than one substance).

The data indicated that 86% of children were covered by some type of health insurance. Of these, eighty-four percent (84%) were covered under Medicaid. If the four voluntary cases in Sarasota were eliminated from the sample, the entire population served by the three pilot sites would be Medicaid eligible.

Early Intervention and Education

National data report a high percentage of delays in foster children in cognitive, language and social/emotional development ranging from 3% to 58% (Hill, et al, 1978). Newer unpublished data suggest the percentages may be even higher. Delays are often not identified in children in foster care. (Academy of Pediatrics, 2003).

Only 6% of children were in some type of program for at risk or developmentally delayed children at the time of pre-assessment. Four of these five were in Early Head Start and one was in a Part C early intervention program.

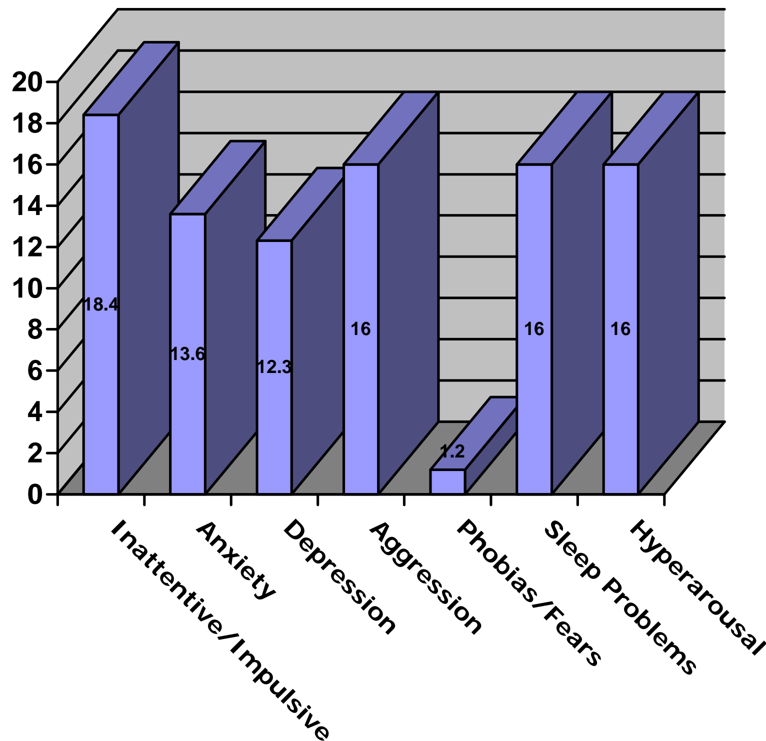
Based on pre-screening using the Ages and Stages Questionnaire during the initial assessment, 37 of 84 children (44%) were identified as being delayed in at least one domain of development. These 37 were referred to Florida's Part C Early Intervention Program (EIP) and 34 (91%) received EIP evaluations. Of these 34, 13 (38%)were found to have developmental delays significant enough to make them eligible (i.e., 1.5 standard deviations below the mean or 25% delay in one or more domains of development) to receive services.

The children in the pilot project are considered at-risk children whose developmental problems typically are in the areas of social/emotional development and language delay, as opposed to established conditions or neurologically impaired children such as Downs Syndrome or Cerebral Palsy. Children served by Part C (EIP) are those that have established conditions or significant developmental delays. Consequently, many at-risk children "slip through the cracks" of the early intervention service delivery system. Unfortunately, they have to wait to get EIP services until their mild delays become severe enough for them to meet the criteria and qualify for service.

Symptoms of Child's Mental Health

Prior to children and caregivers beginning the pilot study, 10% had seen a professional for mental health intervention, generally for parent support and assessment. Based on clinical interview at intake, the therapists indicated the children suffered from the following difficulties.

Figure 4. Therapists' Indication at Pre-Assessment of Children Experiencing Mental Health Difficulties



Of the children completing treatment who were diagnosed with mental illnesses according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV; American Psychiatric Association, 1994), 38% were given the diagnosis Physical Abuse of a Child/Sexual Abuse of Child/Neglect of Child (i.e., DSM-IV does not distinguish between these issues), 28% were diagnosed with Parent-Child Relational Problem, and 7.5% were diagnosed with Disruptive Behavior Disorder Not Otherwise Specified. A few children were diagnosed with other disorders, including Anxiety Disorder Not Otherwise Specified.

Of the children completing treatment diagnosed with the Diagnostic Classification System, DC: 0-3, 35% were diagnosed with Adjustment Disorder, 11.5% were diagnosed with Reactive Attachment Deprivation/Maltreatment Disorder of Infancy, and 11.5% were diagnosed with Traumatic Stress Disorder. Forty-one percent were diagnosed on the Relationship Axis II as Underinvolved. A few children were diagnosed with disorders such as Anxiety Disorder of Infancy and Early Childhood, Mixed Disorder of Emotional Expressiveness, Hypersensitive, and Sleep Behavior Disorder.

Demographics of Mothers Entering the Pilot Project

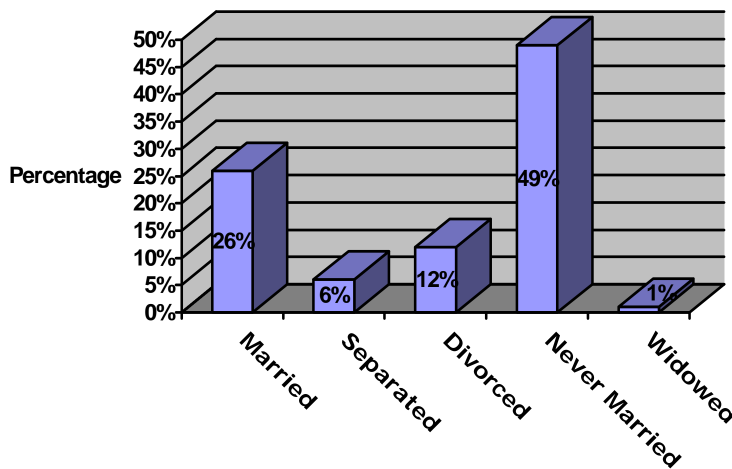
Age

The average age of the mothers when they entered the pilot study was 25 years. Given that the average age of the toddlers was 19 months, the average age of mothers at the time their child was born was 23.5 years. However, 35% were teenage mothers at time of their child's birth.

Marital Status

The majority of respondents (61%) indicated the parents of the identified toddler were not in an ongoing relationship. However, 45% were or had been married. The average time the parents were together, sharing the same household, was 32 months. The marital status of the main caretaker was as follows:

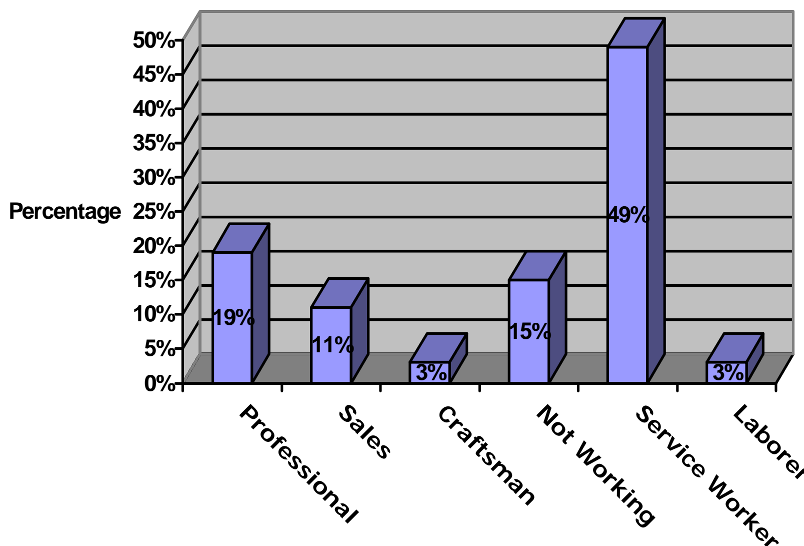
Figure 5. Marital Status of Mothers at the Beginning of Treatment



Employment Status

Thirty-nine percent (39%) of the mothers were employed upon entry into treatment. The majority was in low paying service jobs. The mother's occupational level is as follows:

Figure 6. Occupational Status of Mothers



Income

The family income varied widely, from $0 to $240,000. Four individuals earned $50,000 or more (they were voluntarily in treatment at the Sarasota pilot project). Almost 50% earned less than $10,000.00 per year, and 28% of families earned less than $5,000 per year. Because of the high-income outliers, the most appropriate measure of central tendency is the median (i.e., the income in the middle), and this was $10,824 per year.

Only five mothers were enrolled in the WAGES program. About 57% of the mothers were on Medicaid at the time of assessment. As noted earlier, the entire sample (100%) would be Medicaid eligible if the four voluntary cases were excluded from the sample. The voluntary cases were not part of the original targeted population, although they too benefited from this intervention program.

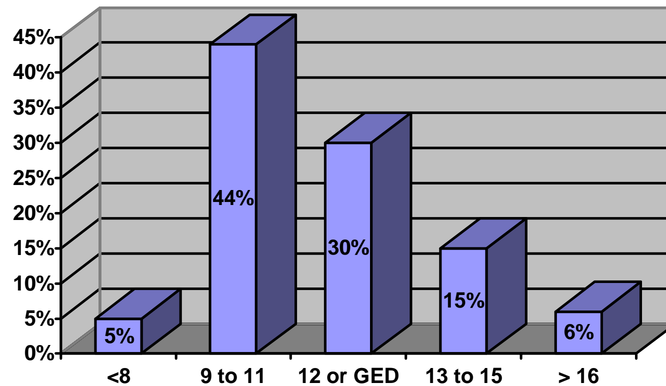
Number of Children

The mothers had between one and ten children, with an average number of 2.8 children.

Education

Forty-nine percent (49%) of the mothers had dropped out of school before graduating from high school. The mother's educational level was as follows:

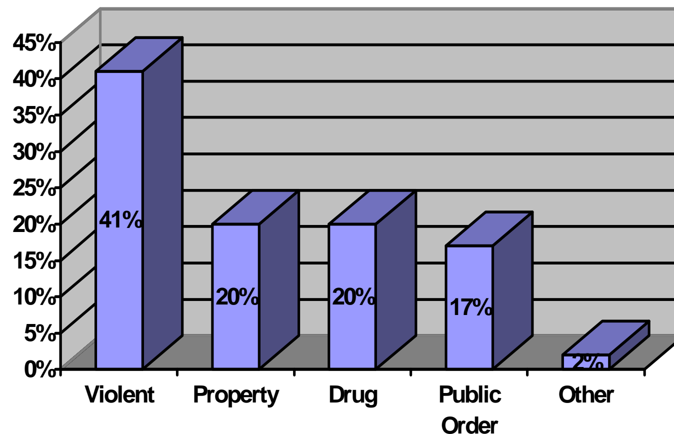
Figure 7. Mother's Educational Level Prior to Treatment



Offense History

Fifty-four percent of the mothers had been incarcerated. The breakdown of offenses for the 54% who had been incarcerated is as follows:

Figure 8. Mother's Offense History



Mental Health

According to the intake interview, the mothers reported a high rate of mental illness. Thirty-eight percent (38%) reported depression and/or anxiety, 4% reported schizophrenia or bipolar disorder, and 20% self-reported drug and alcohol abuse. About 15% of the mothers had been hospitalized for psychiatric problems.

Demographics of Fathers Entering the Pilot Project

Information was received on 68 fathers based on the mother's report during intake assessment. As stated above, 39% were in an ongoing relationship with the child's mother, and only 10% lived in the home.

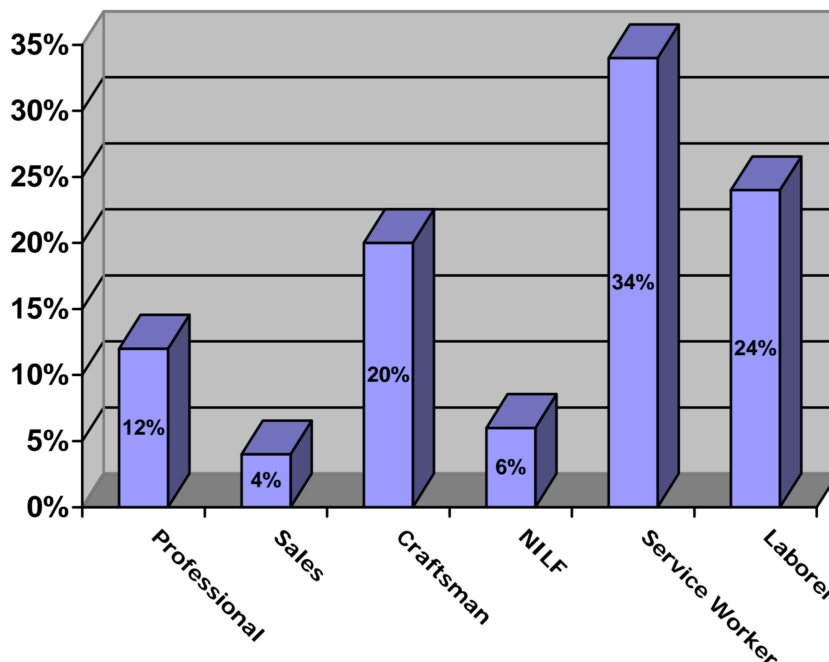
Age

The average age of the fathers in the pilot study was 29.4 years. One child's biological father had died an accidental death.

Employment Status

Most of the fathers (68%) were employed. The father's occupational status was as follows:

Figure 9. Occupational Status of Fathers



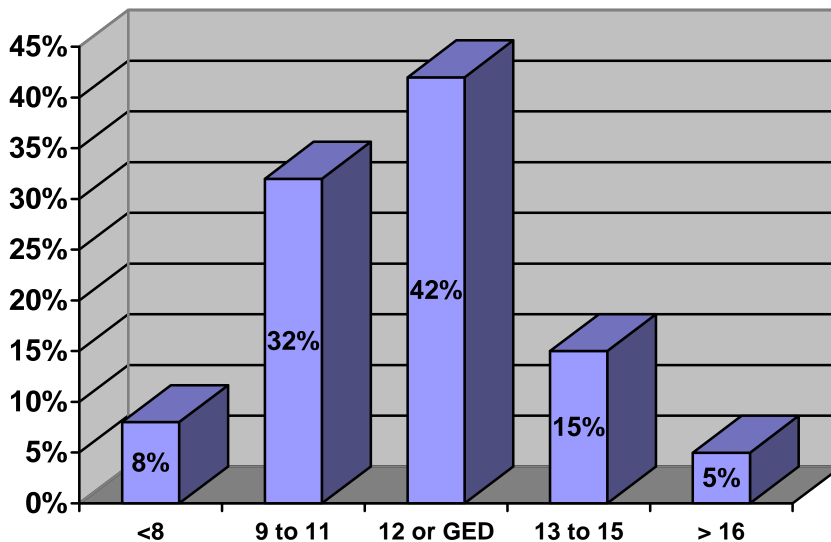
Number of Children

The fathers had between one and fourteen children, with most of them having two children. The average number of children was 2.6. The biological father's name was not listed on 44% of the children's birth certificates.

Education

The father's educational level was as follows:

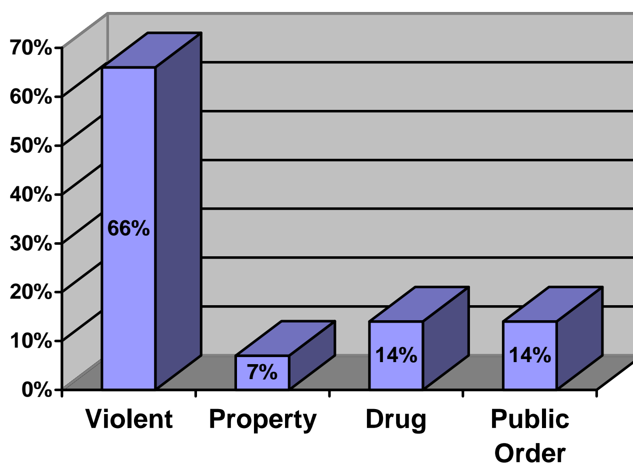
Figure 10. Father's Educational Level Prior to Treatment



Offense History

Sixty-nine percent (69%) of fathers had been incarcerated. The breakdown of offenses was as follows:

Figure 11. Father's Offense History



Mental Health

Of the reporters who knew the father's mental health history, 5% suffered from depression and/or anxiety, 4% from schizophrenia and/or bipolar disorder, and 21% from drugs and/or alcohol.

Other

Of the respondents who were aware of the answer, no fathers were enrolled in the WAGES program. About 11% of the fathers were on Medicaid.

Description of Outcomes Following Completion of Treatment

(Based on individuals completing treatment; N=43)

Reduction of Child Abuse and Neglect

Abuse or neglect occurred in 97% of dyads prior to beginning treatment. None of the dyads completing treatment had abuse reports during treatment, a significant improvement.

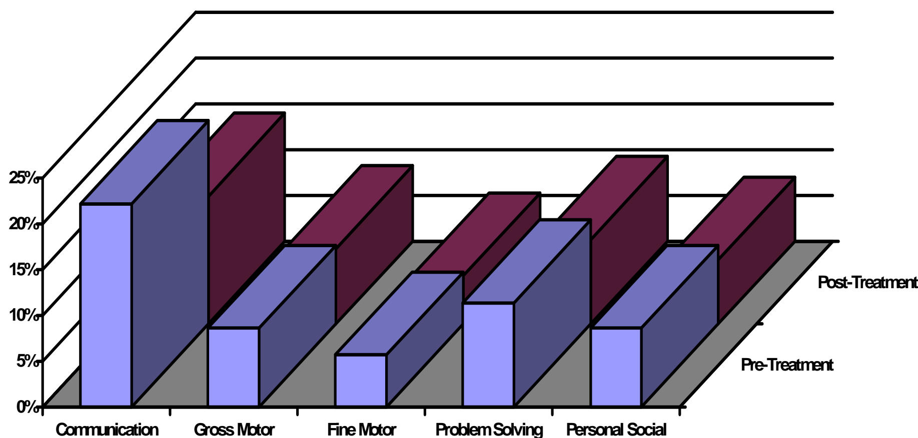
Reunification or Permanent Placement

Parents in the pilot program had increased compliance with DCF case plans, and as a result, reunifications occurred in a more timely manner which is extremely important to enhance the optimal development of young children. All children completing treatment who were out of parental custody at the time of referral were placed back with their families or were permanently placed as a result of the intervention. This included 17 families in Sarasota, 11 families in Miami, and three families in Pensacola.

Improved Health and Developmental Status for Children

Pre and post-tests of developmental status were conducted using the Ages and Stages Questionnaire (ASQ), a parent-administered screening measure designed to assess the children's developmental level. According to the Ages and Stages Questionnaire, 29% of children had developmental delays in at least one domain. In contrast, when caregivers were asked their opinion about whether or not their child had a developmental delay, only 17% of caregivers reporting indicated their child was developmentally delayed. Following treatment, 58% of children improved in their developmental functioning according to the ASQ. The different domains and children scoring in the delayed range were as follows:

Figure 12. Percentage of Children Who Completed Treatment Who Scored in the Delayed Range at the Beginning and End of Treatment



It is noteworthy that improvements occurred in all domains, but particularly communication, problem-solving, and personal social, which are areas that are most likely to be impacted by the intensive mental health interventions with these high risk children and caregivers.

As stated previously, the ASQ was used during pre-screening to determine who to refer for EIP evaluation. Thirty-seven (37) children were identified as being delayed in at least one domain of development. These 37 were referred to EIP and 34 received evaluations. Of these 34, 13 had developmental delays severe enough to be eligible and received EIP services.

Parent-Child Relationship Functioning

Changes in the Relationship based on the Intervention

Parent-child relationship functioning improved significantly in all domains for both parents and children. Parents showed an increase in behavioral and emotional responsiveness with their children and a decrease in intrusive behaviors. Increased responsiveness and less intrusiveness from parents or caregivers will enhance the child's development, positive self esteem, and readiness to learn. Children showed an increase in positive affect (emotions) and enthusiasm with their parents. The children enjoyed playing with their parents much more after the therapeutic intervention. Playing is an important way for children to grow and learn. Both children and parents showed increased responsiveness to each other during the reunion after a brief separation. This indicates much more sensitivity, responsivity, and reciprocity in the parent-child relationship from the pre to the post test assessments. The increased responsiveness from both children and parents is important because early relationships form the basis for all later relationships. If they are positive, the child is more likely to develop optimally and learn to relate to others such as teachers and peers positively. These findings also indicate that these young, vulnerable children with early therapeutic intervention have a much better opportunity for positive development. There is also strong evidence that children who are abused and neglected without intervention are at higher risk for school failure and later violence. (Widom & Maxfield, 2001). In contrast with early interventions, they are more likely to develop well, be able to learn in school, have positive self esteem and avoid negative patterns of behavior.

Description of Evaluation of Pre and Post Observational Assessment

As part of the assessment process, children and their parents participated in a modification of the Crowell Parent-Child Relationship Procedure (Crowell & Fleishman, 1993) before the initiation of treatment and at the completion of treatment. During the procedure, the parent and child participated in an 8-10 minute free play session, followed by a clean-up period, two structured teaching tasks, and a brief separation and reunion. The parents' and children's behaviors were coded on a variety of 5-point scales for each segment of the procedure. The coding scales used for the evaluation were developed specifically for this project. They were based on a modification of the original Crowell scales (Crowell and Chase-Landsdale, 1999) by Heller, et al (1999). They were further modified and adapted for this study by Osofsky, Bosquet, and Hammer (2003). More specifically, parents were scored on their level of positive affect, withdrawal/depression, and irritability/anger/hostility toward the child during the free play and structured segments. Parents were also coded on their ability to follow the child's lead and to be sensitive to the child's pacing and physical space (intrusiveness), their ability to structure the play and the tasks in a way that was developmentally sensitive to the child's needs (behavioral responsiveness) and on their ability to create a positive emotional environment for the child and prevent the child from becoming overly distressed or frustrated (emotional responsiveness). Parents' discipline techniques during the structured task were also scored, including their use of positive discipline (e.g. modeling the correct behavior, praising the child for success) and negative discipline (e.g. shaming the child, physically threatening the child). Children were scored on their level of positive affect, withdrawal/depression, anxiety/fear, irritability/anger/hostility toward the parent, and enthusiasm during both the free play and structured tasks. Finally, the parents and children's behaviors were rated during the reunion following the brief separation. Parents were coded on their ability to provide sensitive comfort to the child, to minimize the child's distress, and to get the child to return to play and exploration (parent's emotional and behavioral responsiveness). The children were coded on their ability to soothe, with the parents' help, and return to play (child's emotional and behavioral responsiveness).

For all scales, a higher score indicated more optimal behaviors. The coding of the pre and post assessment tapes was done by a team of researcher/clinicians from Louisiana State University Health Sciences Center Department of Psychiatry who have expertise in infant mental health but were not at all involved in the design or implementation of the Florida Infant Mental Health Project.

Composite scales were created for data analyses. First, identical scales from the free play and the clean up sessions were averaged to compute mean scores for each of the scales described above. Affect scores were created for the parents and for the children. The parent affect scale included positive affect, withdrawal/depression, and irritability/anger/hostility, such that a high score indicated a high level of positive affect and low levels of withdrawal/depression and irritability/anger/hostility. A similar score was computed for child affect, consisting of positive affect, withdrawal/depression, anxiety/fear, and irritability/anger/hostility, with a high score indicating high positive affect and low negative affect. A parental discipline score was created by averaging the positive and negative discipline scores, such that a high score indicated frequent use of positive discipline techniques and infrequent use of negative discipline techniques.

Of the 43 dyads who completed treatment, 30 completed pre- and post-treatment parent-child interaction procedures. In all 3 sites, at the end of year three, 28 additional cases were enrolled and are currently in dyadic treatment. However, since they were enrolled later in the year, post-test assessments have not yet been done. In other situations, post-test assessment was not completed because the family left area, the mother(s) were jailed, etc. For some subjects, complete data were not available on all segments of the procedure; in those instances, the available segments were scored. Repeated measures analyses of variance showed significant differences in parents' and children's scores before and after treatment that are illustrated graphically in Figures 13-19 and shown according to percentage of improvement in Table 6.

Figure 13. Parental Intrusiveness by Treatment Status

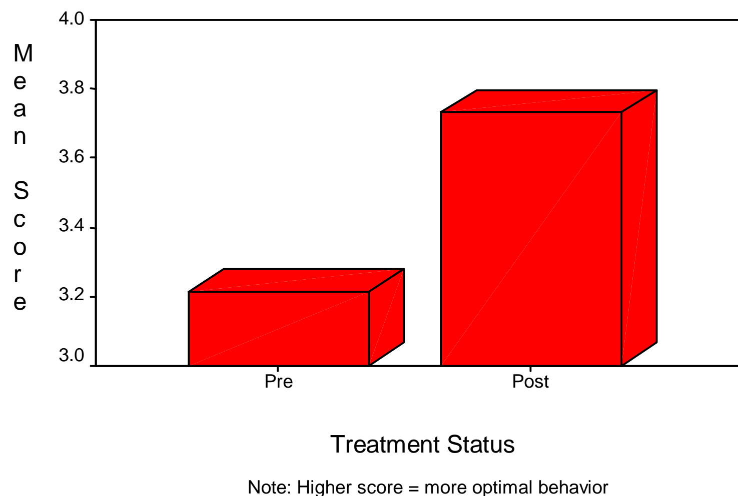


Figure 14. Parental Behavioral Responsiveness by Treatment Status

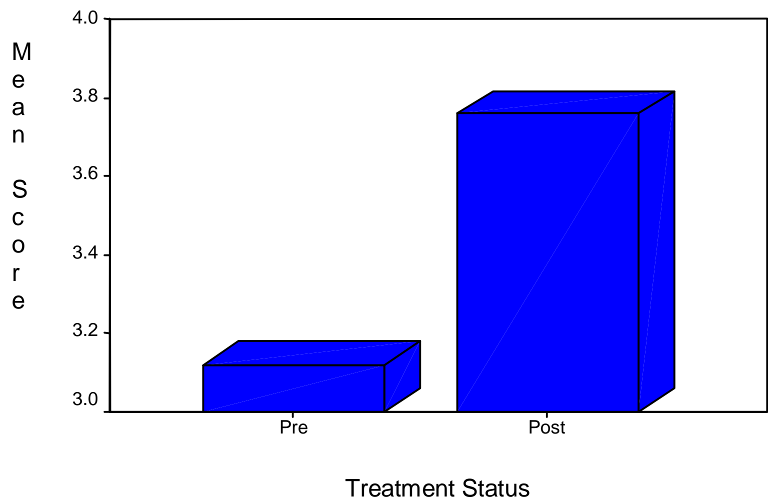


Figure 15. Parental Emotional Responsiveness by Treatment Status

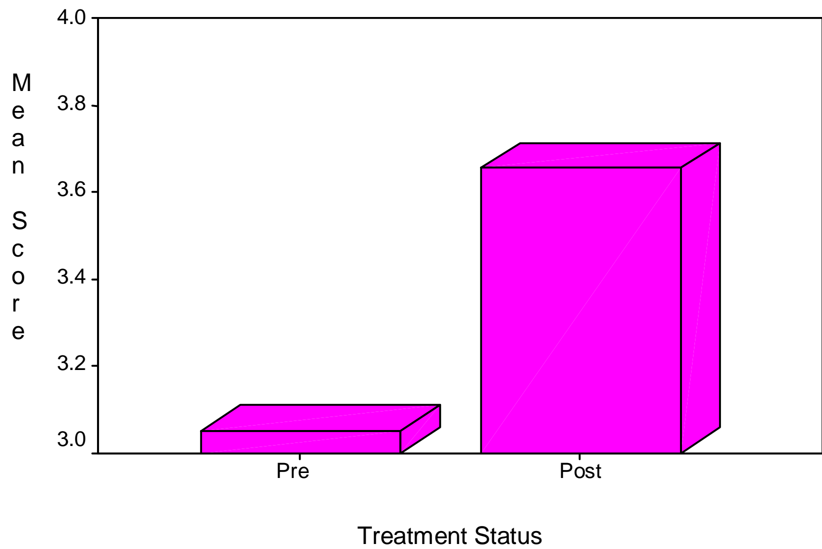
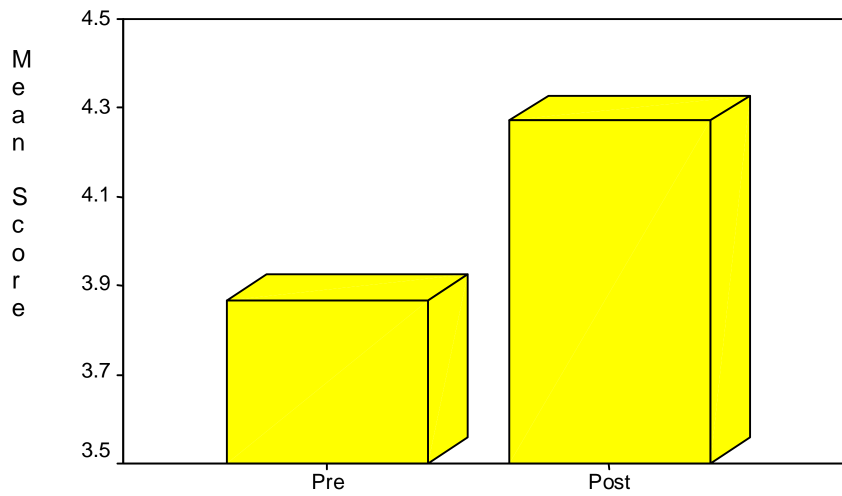


Figure 16. Child Affect by Treatment Status



Note: Higher score = more positive and less negative affect

Figure 17. Child Enthusiasm by Treatment Status

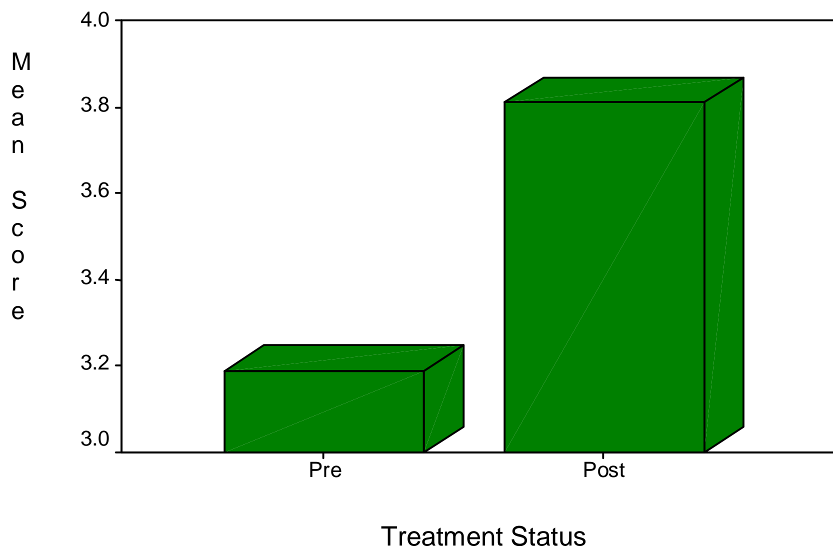


Figure 18. Parental Responsiveness at by Treatment Status Reunion

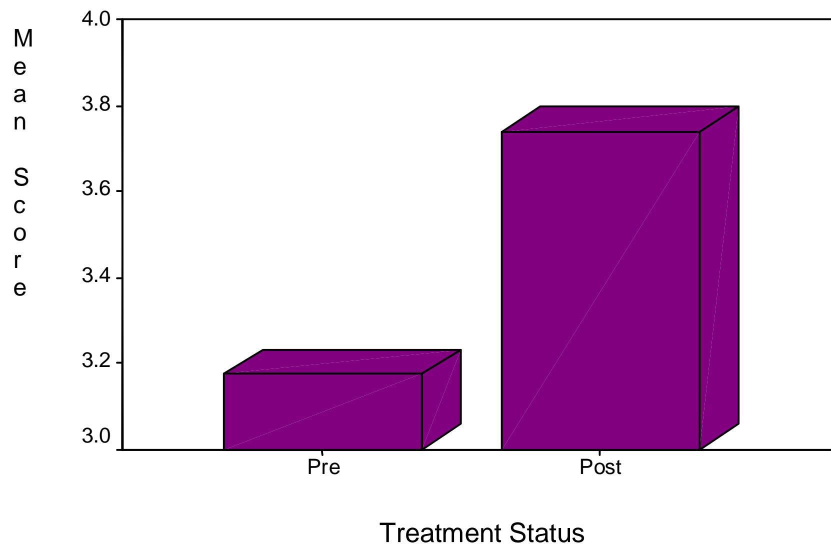


Figure 19. Child Responsiveness at Reunion by Treatment Status

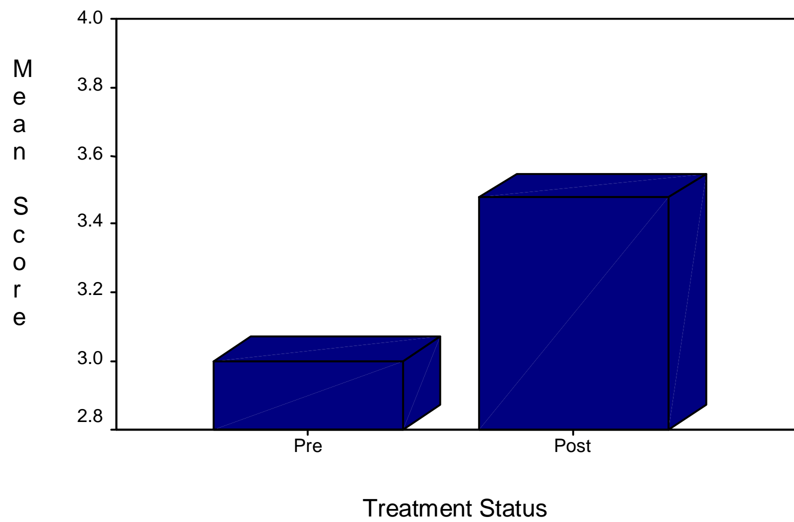


Table 6. Pre-Post Scores on the Parent-Child Relationship Scale

Scale	Score	Pre Treatment	Post Treatment
Parental Intrusiveness	Poor	35%	17%
	Optimal	38%	62%
Parental Behavioral Responsiveness	Poor	27%	14%
	Optimal	27%	59%
Parental Emotional Responsiveness	Poor	27%	14%
	Optimal	23%	59%
Parental Discipline	Poor	4%	16%
	Optimal	60%	80%
Child Affect	Poor	3%	3%
	Optimal	50%	86%
Child Enthusiasm	Poor	23%	7%
	Optimal	33%	66%
Parent Responsiveness: Reunion	Poor	24%	15%
	Optimal	36%	67%
Child Responsiveness: Reunion	Poor	36%	19%
	Optimal	28%	48%

Table 6 indicates that parents were more emotionally and behaviorally responsive to their children and were less intrusive and that their children enjoyed playing with them more than they did during the pre assessment before treatment began. Many more parents were also able to discipline their children appropriately following the therapeutic intervention. After separation from their parents, the parents were more responsive to their children who were better able to be comforted by them and return to play. Results were similar across the Sarasota, Pensacola, and Miami sites.

An examination of the distribution of scores showed decreases from pre- to post-treatment in the percentage of subjects who received the worst scores on the various scales (1 or 2 out of 5 points) and increases in the percentage of subjects who received optimal scores (4 or 5). The following graphs (Figures 20 and 21) display significant changes from the pre to the post evaluation.

Figure 20. Percentage of Dyads Scoring in the Optimal Range

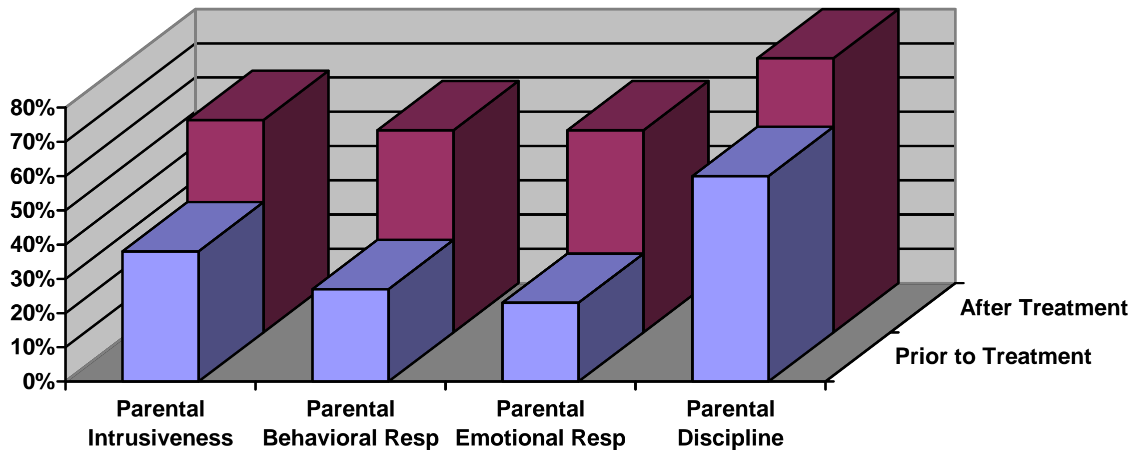
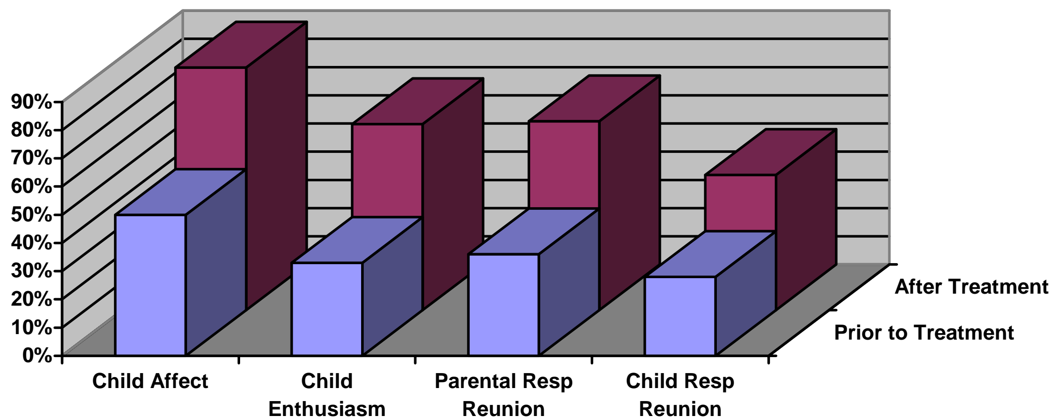


Figure 21. Percentage of Dyads Scoring in the Optimal Range



Demographic variables were examined for possible differences in the effects of the intervention. T-tests were conducted comparing demographic groups on pre-treatment scores, post-treatment scores, and difference scores (i.e. post-treatment score minus pre-treatment score). Scores were compared for dyads in which the child's parents were still in a relationship (47%) versus dyads in which the child's parents were no longer in a relationship (53%). Only one significant difference was found: Children of parents who were still involved showed lower enthusiasm scores pre-treatment compared to children of parents who were not still involved. Scores were also compared for children of Caucasian background (45%) versus children of African-American, Hispanic, or bi-racial background (55%). There were no differences between ethnic groups on the difference scores for these variables, indicating that Caucasian and minority dyads showed similar levels of improvement over the course of therapy.

Following treatment, caregivers were asked a number of questions. Their responses were as follows:

Table 7. Caregiver Satisfaction Survey Results

Question Asked	% Answering Yes
Do you think that your relationship with your baby has improved as a result of treatment?	95%
Has your child changed positively since the beginning of treatment?	91%
Is your child different emotionally?	67%
Has your child's behavior changed?	76%
Has your parenting changed since the beginning of treatment?	77%
Has your family life changed as a result of your involvement in this pilot study?	73%
Have you learned anything new from being in this program?	96%
Has treatment helped with the problems you and your child were having?	85%

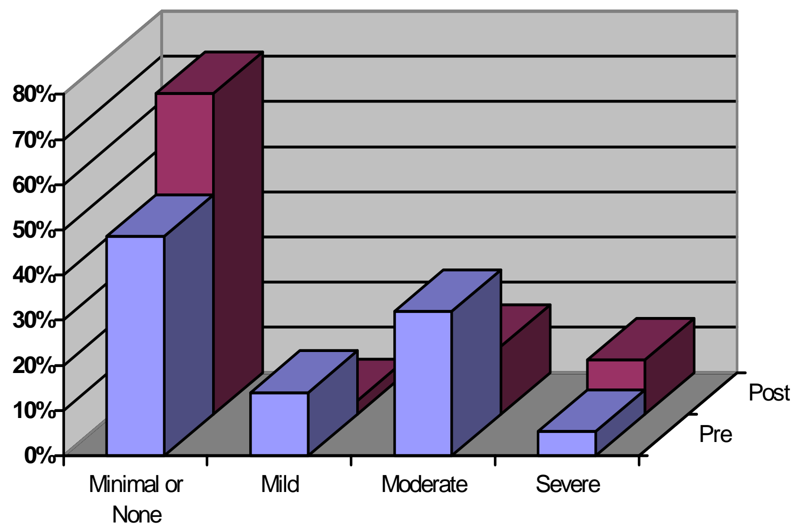
Parental Stress

A large number of caregivers referred were ordered into treatment by the court system. While this referral method makes it more likely that the caregiver will attend treatment, it also increases defensiveness related to parenting skill and need for treatment, at least initially. This was evidenced during the evaluation. On the Parenting Stress Inventory, Short Form (PSI), 58% of caregivers responded in a defensive manner indicating little or no stress despite the fact that they were referred by the court or their child was placed in protective custody. Thus, the measures were invalidated. Therefore, data analysis was not conducted on this measure, and it is not recommended that this measure be used in the future for this reason.

Maternal Depression

Caregivers were administered the Beck Depression Inventory prior to and following treatment. The BDI is a measure of depressive symptomatology that classifies individuals as either have minimal, mild, moderate, or severe depression according to their self-report answers. The following chart visually describes depressive symptomatology in caregivers prior to beginning treatment and following treatment.

Figure 22. Pre versus Post Depression in Caregivers According to the BDI



As can be seen in the above graph the percentage of depressed caregivers decreased from 51% pretreatment to 29% post treatment, only half of caregivers indicated experiencing little or no depression pre-treatment. However, 71% of respondents indicated experiencing little or no depressive symptomatology following completion of treatment. Individuals with mild and moderate depressive symptoms also decreased, but an increased number of caregivers reported severe depression. This suggests that, for the severe group, more intensive therapy was needed to address the caregivers' depression than the dyadic intervention which focuses on the mom/baby relationship.

Other

The program was shown to have a positive impact in many areas of the participants' lives. For example, of the 11 individuals completing treatment in Miami, four re-entered the workforce, three returned to school, two continued working (i.e., had jobs at the beginning of treatment already), though two were still unemployed. Therapists described other outcomes in these families, including:

- Early detection of developmental delays in the identified child and his/her siblings
- Follow through with the primary medical needs of the children
- Parents advocating on their children's behalf
- Mothers recognizing the need for and establishing support systems

Goal 2: To document the components of quality infant mental health interventions and analyze them for replicability, sustainability, effectiveness, and affordability for potential use in a statewide system.

Essential Components of Assessment:

An appropriate assessment process for an infant or young child must take into account all the relevant areas of a child's functioning. These areas include:

- Presenting symptoms and behaviors
- Developmental and medical history
- Family interaction and functioning, as well as cultural and community patterns
- Caregiver-child relationship and interactive patterns
- The child's constitutional and maturational characteristics
- Child's current developmental status
- Child and family strengths

Essential components of treatment

An essential component of treatment for very young, high-risk children and caregivers is relationship-based parent/child psychotherapy, focusing on symptoms or problematic behaviors that may be a result of abuse and/or neglect. The therapeutic process involves behavior-based strategies, play, as well as verbal interpretations. For very young children, who often cannot express their feelings in words, actions shown through play and other means may be the most effective way of helping them. The intervention strategies support attitudes and behaviors that optimize development and encourage positive emotions and behaviors. The therapeutic work also addresses discipline, reciprocal play, and conflicts. Therapeutic strategies include such techniques as "speaking for baby" to help sensitize the caregivers to the young child's feelings that may be manifest through their behaviors, parental guidance, and case management that supports the family.

The treatment strategies recommended and used in the infant mental health pilot projects were effective in decreasing the negative behavioral and emotional patterns that characterized the caregivers and children's relationships when they entered treatment. These changes were shown clearly in the observational evaluations carried out before and after the therapeutic intervention. For this reason, a child parent (dyadic) psychotherapy model for treatment is recommended to enhance the development of such high risk children and their caregivers.

In this pilot sample, approximately half of mothers experienced depression, which often makes it difficult for them to initiate or follow through with services. While many of the mothers found help with their depression through the dyadic work with done their infant mental health therapists, the mothers with severe depression made less progress than the mildly depressed mothers. The mothers with more severe depression may have benefited from additional individual counseling and psychopharmacological intervention to address their depression and other mental health issues in order to have the most positive effect on the parent-child relationship.

"Engagement", which includes case management and outreach activities, is also reported to be a critical component of mental health service to this targeted high-risk population. All three pilot sites reported the need for extensive engagement activities in order to get the families into treatment and to keep them coming. The parents in this high-risk sample population have a lack of trust in "the system" that threatens to remove or has already removed their children. They do not typically seek out treatment resources or maintain involvement in treatment on their own. Also, they often lack the ability to coordinate basic life tasks or to manage their own mental health/substance abuse issues. Consistent with Maslow's Hierarchy of Needs, basic issues such as housing, medical care, safety, and transportation must be addressed, in addition to the provision of dyadic treatment. Consequently, case management and outreach services are seen as critical components in the mental health treatment of families with complex, multiple issues.

Because of their complex issues, high risk groups such as those participating in this pilot study may have greater setbacks (relapse, etc.) so that completion of treatment and attainment of treatment goals may be more difficult and less successful than with a less at-risk population. Persistence and extensive outreach and resources are necessary to serve this population.

Replication

What are the likely issues in replicating the initiative statewide?

The infant mental health pre and post evaluations are thorough and comprehensive. However, agencies may not be equipped to follow the assessment protocol in its entirety or may find the costs associated with these evaluations prohibitive.

Few clinicians have the experience, skills or credentials to provide dyadic therapy to children 0-3 and their parents. In addition, there are few mental health supervisors who have the expertise in infant mental health to provide the clinical supervision required for unlicensed therapists. An extensive training, credentialing, and supervision program would be needed on a statewide basis to assure quality services.

Services provided as in-kind at the host agencies for the three pilot projects might not be available at other community-provider sites, thus driving up the costs of evaluation and treatment, making it prohibitive to invest as much in "engagement". Engagement/case coordination/outreach activities that are not funded by Medicaid may have to be reimbursed as targeted case management services as they are critical to enlisting and keeping clients in treatment over time.

Additional analyses were run to evaluate differences between the mothers/caregivers and children who benefited from treatment, and those who did not. The following characteristics describe those who benefited most from the intervention:

- The children were in stable homes
- The children had a stable caretaker
- This was the child's first contact with either the court or the Department of Children and Families
- The mothers experienced mild to moderate depressive symptomatology rather than severe depression

These data are important in considering how to prioritize resources to assure the greatest compliance, and therefore, success with such an early intervention program. Data consistently supports the critical idea that "earlier is better" as defined below.

- The earlier in a child's life that developmental or social emotional difficulties can be identified, the less entrenched are the abnormal developmental patterns and the simpler the intervention and more likelihood of success.
- The earlier the child/parent relationship is identified as in need of intervention the less intervention is needed.
- The earlier in a family's maladaptive patterns, the easier to change. Families with fewer challenges require fewer resources to rehabilitate than those with multiple, complex issues. Mothers with mild to moderate depression can take advantage of treatment easier than moms with severe depression.
- The earlier in the system, the easier to change. Targeting families prior to court intervention or those families for whom it is the first contact with child protection or the court will require fewer resources than the families firmly entrenched in dysfunctional patterns

Stability seems to be an important factor. Interestingly, there was much more stability after completing the intervention program for all dyads. With the first contact with child protection or the court, one might surmise that the mother/caregiver and child is more likely to follow through with recommendations as compared with those who have become more firmly entrenched with maladaptive patterns for a longer period of time. Finally, it is noteworthy that mothers with less significant depressive symptoms were able to comply better with treatment related to their own motivation as well as mental illness not standing in the way of their being able to help their child and themselves.

Recommendations

- Expansion of Medicaid billing (fee for service) is recommended to include "engagement/case coorindation/outreach" activities as defined by "pilot" project.
- Expand caps on number of individual/family therapy and In home-on site (ITOS) services for 0-5 population.
- Explore utilization/certification of "pilot" assessment to replace comprehensive assessments for 0-5 and/or create equitable levels of reimbursement for 0-5 in-depth assessment.
- Create an Infant Mental Health Specialist training, credentialing, and supervision program on a statewide basis to develop a cadre of competent therapists for serving this population.

Goal 3: To identify barriers and solutions for systemic changes in infant mental health such as appropriateness of diagnostic labels and measurement tools, reimbursement possibilities including Medicaid and third party billing, and need for ancillary services.

Barriers and solutions

Several barriers and possible solutions have been identified in the course of this three year pilot project. The most frequently reported barriers will be discussed, and others will be included in Table# 8.

Barrier: Reimbursement for Engagement.

A significant part of the services delivered in the pilot project was "Engagement." This service was considered by all three pilot sites to be critical in reaching out to families to get them engaged in the treatment program, as well as keeping them involved in services. Pilot project staff strongly believe that this service was important in the cases where completion of treatment occurred because it was provided by a trained Master's level therapist who knew systems theory, the importance of establishing trust in a therapeutic relationship, and the reasons for, as well as an approach to dealing with treatment resistance. There is no current means of reimbursement for this service within Medicaid or other insurance programs.

Solution: Many of the "engagement" services consisted of phone contact with the client or collaterals involved in the life of the family or child. These collateral contacts involved the child's child care provider, pediatrician, case manager, or the parent's therapist, other treatment providers, or extended family members. Much of this work could be described as mental health case management. The current criteria regarding the provision/billing of mental health case management restricts this service/billing to the assigned case manager only. One solution would be to expand this service to both the assigned case manger and assigned clinical therapist, noting that services could not be provided at the same time, on the same day by both. The total amount of service allowed each month could remain the same, so as not to increase the cost of this service. This solution would also assist in coordination of services between the mental health case manager and clinical therapist.

Other possible solutions would be to match Alcohol, Drug Abuse and Mental Health (ADM) dollars under the cost center of "outreach" to Medicaid dollars for direct therapy services. "Engagement services" meets the description of Outreach services under ADM. Another option is to explore the use of EPSDT funds for case management.

Barrier: Pre Authorization Of Services

Child Development Center in Sarasota reports that In home-on site (ITOS) services through Medicaid will be necessary in order to provide the level of service needed to be effective after completion of the pilot. Unless an agency qualifies for exemption, ITOS services require pre-authorization through First Health. The pre-authorization form is four pages long and takes a trained clinician approximately 20 to 30 minutes to complete and fax. Tracking the approved number of hours of service (if approved) is also time consuming. This time is at the cost of the agency, a luxury most not-for-profit centers cannot afford. As a result, pre-authorization requirements are reported to result in increased caseloads in order to cover the cost of services, which in turn, results in increased workload and stress for clinicians, as well as concern for diminished quality of services. Turn over in clinical positions as a result of the pre-authorization process has been reported. Further, there is uncertainty as to the knowledge level of the person authorizing needed services to children under age three.

Solution: Develop specific guidelines for agencies providing infant mental health services for children 0-5 to become exempt from pre-authorization of ITOS services, and/or require agencies to develop an internal utilization review process for the initiation and continuation of ITOS services, subject to audits by relevant state agencies.

Barrier: Inadequate Funding For Children Of "Working Poor" Or Children Without Insurance

There is a growing number of children/families without any type of insurance, including Medicaid. These are families who earn just above the cut off for eligibility for Medicaid. Many of these "working poor" families have children who are at-risk for out of home placements. The pilot funding through the ADM office has allowed Child Development Center in Sarasota to treat these families following re-unification to protect and prevent further incidents of abuse/maltreatment or relapse in the mother. Without ADM funding for infants/young children, treatment to the un-insured will be impossible.

Solution: According to the ADM office, during fiscal year 2001-2002, 110 million dollars was spent on treatment services for all children in the state of Florida. Yet only 10 million was spent on children under the age of five years. A possible solution would be to adjust the percentage of ADM funding for children 0-5 to be more commensurate to the proportion of the population they represent. Based on the Florida Statistical Abstracts 2002, Table 1.11, the total population in Florida is 15,982,378 and there are 945,823 children under five years 5.9% of the total population. From the same source, the number of children under 19 years is 4,048,632, so children under five are 25.3% of the 0-19 population. If funding were more commensurate with population, funding for children under five would be a substantially greater portion of the amount spent on services for children, i.e. 25% of 110 million dollars is 27.5 million dollars.

Barrier: Ineligibility Of At-Risk Children For Part C Early Intervention Services.

Both national and Florida specific data show that developmental delays are prevalent in children in the foster care system. Young children are not receiving developmental assessments to identify delays early when treatment is most effective. For those few who are evaluated, often their delays are not yet severe enough to qualify for early intervention and must wait until they get worse.

Solution: Require developmental evaluation for all children in foster care. Expand early intervention eligibility to include children in foster care with risks or mild delays.

Table 8 summarizes these and other barriers and solutions that were identified through the course of this pilot project.

Table 8. Barriers and Potential Solutions

Barriers	Potential Solutions
Inadequate funding for infant mental health services, including assessment, treatment and engagement through existing sources	Increase ADM funding for children 0-5. Plans for statewide privatization of foster care as well as the change from Medicaid fee-for-service to a prepaid plan may offer opportunities (or threats). If infant mental health services are prioritized by the administering agencies in each community, IMH program costs can be budgeted within carve-out revenues/expenses, as being done in Pensacola.
DCF caseworkers often do not stay in contact with IMH program regarding child's progress, resulting in uninformed decisions being made regarding the child's placement	Training for therapists, social workers, and case workers involved in the foster care sysem in the identification and treatment of young children with mental health problems could help to improve communication and case planning for children involved in the dependency system.
Lack of funding for services for clients without Medicaid or other insurance	Increase collaboration with Early Intervention Program and ADM to fund treatment, as well as with School Readiness programs for prevention efforts.
Frequent no shows or inconsistency in keeping appointments and dropouts	Increased effort on the part of foster care caseworkers to help keep the client compliant with therapy appointments.
More timely provision of referrals to the program	Provide in-service trainings and presentations to increase awareness and understanding of early identification and treatment during the first few years of life in order to prevent and/or reduce more serious problems later in development.
More timely provision of Part C and other collateral services	Increase interagency communication, cooperation and collaboration efforts.
Resistance to treatment in dependency cases due to substance use and mental illness	More timely provision of collateral treatment (adult mental health, substance abuse and domestic violence services) for parents. Another possible solution, given limited resources, is to target families who are more motivated and compliant with case plans. These include families with children who have not yet been removed from the home and/or families who have never had a child removed before, i.e., first time to have a child in the child welfare/dependency system.
Additional time needed for assessments, treatment, and engagement services for mothers with developmental delays	Allow additional units of service for parent/child dyads with developmental delays
Transportation	Shift to ITOS model for very young children. Increase Medicaid support of transportation costs for those dyads without transportation who receive treatment at centers.
Difficulty in achieving adequate and timely communication with DCF workers.	Increased support from DCF administrators at the local level.

Policy Implications

Recommendation #1: Intervene early in a family's cycle of risk.

Analysis of the families who completed intervention suggest the characteristics of those most likely to comply with the treatment would include:

- families who have a child in the welfare system for the first time
- families who may be under protective supervision but have not yet had their child removed from the home and placed in foster care.

The more entrenched families are in the system and the more complex risks, the less likely the families were to complete treatment. Those who completed treatment benefited as evidenced by 100% reunification or permanent placement outcome, and no further reports of abuse. The earlier mom/baby dyads are identified for treatment, the more likely they will benefit from the treatment.

Recommendation #2: Prevent or reduce multiple placements of infants and toddlers.

Florida law requires permanency placement within 12 months, yet, the average is 60 months in Dade County. Many children in foster care have multiple placements before their first birthday. While placing children in multiple foster homes is detrimental at any age, it can be most damaging during those first few years of life during the "window of opportunity" for maximizing healthy attachment. Many of the children in the pilot achieved permanency in a shorter period of time than usual. Train judges, lawyers, and DCF workers about the importance of permanency placement and the negative impact of multiple transitions on infants and toddlers.

Recommendation #3: Fund Florida's Part C early intervention system to a level that will enable them to serve infants and toddlers in the foster care system who are at risk for developmental delays, but not yet delayed enough to meet eligibility criteria.

Speech, language and cognitive problems often co-occur with emotional problems and exposure to violence in young children. The national prevalence of delays reported among foster children ranges from 3% to 58%. Preliminary data from Miami's PREVENT project revealed that more than half of the maltreated infants, toddlers and preschoolers had significantly delayed cognitive and language development. This pilot project also found that a high percentage, 44%, had a delay in at least one domain of development, based on the Ages and Stages Questionnaire. Children in the foster care system are at risk for social/emotional, cognitive and language delays due to environmental neglect or maltreatment. The Part C early intervention program (EIP) in this state serves infants and toddlers who have established conditions or significant developmental delays, not at-risk children. Unfortunately, many at-risk foster care children must wait until they are significantly delayed before they are eligible for EIP services. It may be more cost effective to fund Florida's EIP system to a level that will enable them to serve at-risk children in order to prevent, ameliorate or reduce disabilities in children as well as reduce later more costly intervention services such as juvenile justice, teen pregnancy, and special education.

Recommendation #4: Accept pilot project's assessment protocol for Comprehensive Assessments.

Comprehensive behavioral assessments by community mental health providers are now required for all children in foster care, including children 0-5. A comprehensive assessment that encompasses the elements of the pilot project (both developmental assessment and parent/child relationship assessment) appears to be very useful in serving this population. In District One, Lakeview Center is the provider of comprehensive assessments for all children in foster care in the district and uses the pilot project assessment protocol which is a more helpful protocol than current guidelines for comprehensive assessments.. Lakeview Center is also developing a psychosocial assessment form that meets requirements of their various accrediting agencies. Consequently, some sections of the state's guidelines for comprehensive behavioral assessments of children in foster care may need to be rewritten to be more specific to the 0-5 population.

Recommendation #5: Expand Medicaid billing to allow reimbursement of "engagement" activities as defined by pilot project or find other means to compensate for needed "engagement" services.

Involving families who are depressed, drug dependent or otherwise disengaged or disenfranchised in treatment is extremely challenging. Even court-ordered families often failed to show up for appointments or comply with treatment. These families with extensive problems need "to be engaged", encouraged, hand-held to start and sometimes to finish treatment. Because of the need to involve primary caregivers in dyadic treatment, engagement activiies were necessary to providing effective interventions in the lives of high risk infants and toddlers and their families involved in the dependency system. Engagement services were deemed critical to the completion of treatment plans that resulted in reunification or permanent placement. Although engagement was essential to these families to participate in treatment, few, if any, funding sources are available for "engagement" services. Reimbursement for engagement services needs to be addressed in existing reimbursement systems for services to infants and toddlers and their families.

Recommendation #6: Provide individual psychotherapy and/or psychopharmacological treatment in addition to dyadic treatment for severe maternal mental health and substance abuse problems.

The dyadic treatment approach focuses primarily on mom/baby interaction and relationship, but may also provide therapeutic benefit for some social/emotional issues affecting the parent as an individual. However, based on the demographics of this population, there are severe intergenerational abuse, neglect, violence, dysfunction and mental health problems which may necessitate specific adult mental health treatment and/or substance abuse treatment in addition to the mom/baby dyadic therapy. Treating the mom/baby relationship without regard to the mother's other mental health issues is likely to interfere with the long-term success of the dyadic intervention.

Recommendation #7: Reduce transportation barriers.

Transportation is a major barrier to accessing services. While this is a barrier that crosses many human service programs, it appears to be particularly relevant to effective provision of intervention efforts with high-risk infants and toddlers whose treatment requires involvement of primary caregivers. While older, school-aged children can be transported independently by buses and vans, infants and toddlers should not be transported without caregivers, who also need to be involved in the treatment. Expansion of Medicaid funding for transportation of infants, toddlers and their parent(s) would reduce this barrier to treatment.

Recommendation #8: Promote service integration at the local and state level.

Interagency communication, collaboration and cooperation are lacking at both the state and local levels. All three sites reported problems related to this issue. Effective intervention for this population requires comprehensive, integrated treatment planning. Too often, progress was thwarted by lack of coordination of the programs serving these children. Effective mental health services for children 0-5 and their families need to be coordinated with other human service programs. The following is a listing of some of the programs serving children 0-5 and their families that should be coordinated with mental health services:

Foster Care and Protective Investigation services

Early Intervention Program (Part C) services

School Readiness services (Subsidized Child Care, Pre K Early Intervention, Head Start, and Early Head Start)

Healthy Families Home Visiting Program

Health Start Home Visiting Program

Child Health Check Up Program (EPSDT)

Mental health/Substance abuse programs

Welfare to work

WIC

Goal 4: To develop model infant mental health treatment programs which can be replicated statewide.

A great deal has been learned from the pilot infant mental health programs in Florida that can be replicated. However, replication will require advanced training of mental health professionals in the specialized field of infant mental health. This need was addressed widely during the program. The assessment protocol used in this project is extensive and current Medicaid reimbursement rates for the 0-5 assessment may not cover costs. Nevertheless, it appears to provide valuable information about how the infant and parent/caregiver are functioning and what problems need to be addressed. The treatment strategies that are learned with training could be used as a model for community mental health clinics across the state to begin serving young children. Replication also should involve collaboration with other agencies and services such as Part C, child care programs, juvenile courts and health systems. Replication will require an increase in awareness, training, and collaboration among agencies.

Goal 5: To build capacity in the infant mental health field, especially in the areas of assessment and direct therapeutic interventions.

When the project began in 2000, Florida had very few, if any, mental health professionals trained specifically in infant mental health. Dr. Joy Osofsky had begun work with the juvenile court in Miami in 1997 and had provided in-service training for their therapists and others in the community. This training involved approximately 50 hours per year. In order to begin this pilot project, a two-day training was held in New Orleans at the Louisiana State University Health Sciences Center with therapists and supervisors from Miami, Pensacola, and Sarasota during which the intervention team observed evaluations and learned different treatment strategies.

After the initial orientation, project therapists met individually with Dr. Osofsky to receive specific training and supervision on how to carry out the infant-parent relationship evaluation and therapeutic treatment. Additional training occurred at least four times a year for the first year for all 3 pilot project staff. Ongoing consultation and supervision was made available for individual cases either in person, by telephone or email. In addition to the training provided by Dr. Osofsky, a two-day training in the Diagnostic Classification System, DC: 0-3 was provide by Dr. Robert Harmon in February, 2002.

Dr. Joy Osofsky provided approximately 400 hours of training over three years. Dr. Osofsky was the lead trainer for all sites. All day training workshops have been done in Miami, Pensacola and Sarasota. In additional, training and supervision workshops have been done at least two times each year through the Harris Center for Infant Mental Health, Department of Psychiatry, Louisiana State University Health Science Center, New Orleans. In addition, over 40 additional hours of training were provided by other mental health experts, such as another nationally known expert in the field of infant mental health, Dr. Robert Harmon who is Head of the Division of Child Psychiatry at University of Colorado Health Science Center.

Project leaders at each site have developed other training opportunities for additional staff at their agencies. Sarasota pilot staff, Kathryn Shea and Kela Miller, have provided several one and two-day trainings for 17 additional mental health therapists who work in their community-based child welfare project. Pensacola pilot project site staff, Sandra Lee and Pam Carr, was instrumental in arranging training efforts in District One to establish assessment and treatment protocols that are based on the pilot project model for therapists at Lakeview Center who perform Comprehensive Behavioral Assessments. Project Director of the Miami pilot project, Dr. Lynne Katz was instrumental in creating intensive one year and 6 month training programs in West Palm Beach and Miami respectively, which will train approximately 50 therapists. The two core pilot therapists in Miami, Silvia McBride and Karen Haag, have participated in the year long training.

Since the pilot began and also since the new Community Mental Health Medicaid policy for 0-5 went into effect May 2002, as well as implementation of the requirement for comprehensive assessments of children 0-5 in foster care, training in infant and early childhood mental health has greatly increased across the state. One example is the increased training opportunities in DC: 0-3, the Diagnostic and Classification system appropriate for infants and toddlers. These trainings have been provided by the Agency for Health Care Administration (AHCA) and Children's Mental Health in the Department of Children and Families (ADM). To date, approximately 150 mental health providers from around the state have received DC 0-3 training at no cost.

The therapists and supervisors at each site reported that progress has been made and the program has become better understood and more valued by their host agencies. All three pilot site host agencies have committed to continuing and expanding the program.

There have been several trainings that have occurred or are in process that are related to the infant mental health pilot project and what has been learned in the past three years of the project. Table 9 outlines some of the trainings that have been developed during this pilot project.

Table 9. Infant Mental Health Trainings in Florida

Description of Training	Purpose	Description of trainees	Dates
Training for licensed therapists – Year 1	To build IMH capacity in Broward County	20 licensed therapists from Broward County	August 2003-August 2004
Training for licensed therapists – Year 1	To build IMH capacity in the Tallahassee area	10 licensed therapists from the Tallahassee area	August 2003-August 2004
Training for licensed therapists – Year 1	To build IMH capacity in Miami	20 therapists from Miami	February 2003 thru August 2003
Training for Therapists- Year 2 Follow-up	To provide supervision/clinical case discussions	30 from Miami/Dade County	February to September 2004
Training for licensed therapists – Year 1	To build IMH capacity in Palm Beach County	23 licensed therapists from Palm Beach and 7 from Miami	August 2002- September 2003
Training for Therapists- Year 2 Follow-up	To provide supervision/case discussions	20 licensed therapists from Palm Beach	August, 2002 through August 2003

Increased level of awareness of the mental health needs of infants, toddlers, preschoolers and their families in their respective communities.

An increased level of awareness was evidenced by increased referrals of young children. In Miami, an efficient referral process and collaboration has developed with the head administrative judge of the 11th circuit, Judge Cindy Lederman, so that Dependency Court judges may now recommend the infant mental health program as part of case plans for evaluations and dyadic treatment.

Increased community awareness of impact of early relationships and experiences is also evidenced by increased referrals for assessment and treatment, as well as requests for training and consultation. Other community mental health therapists in all three locations contact the pilot project staff for consultation related to young children.

Each site has greatly increased awareness in their own communities as evidenced by increased funding opportunities, media coverage, and infant mental health task forces. The Miami pilot, with the support and leadership of Judge Cindy Lederman, has been successful in getting federal funding for a Safe Start project as well as funding for the first Early Head Start program in the nation for maltreated infants and toddlers. National Public Radio, (NPR) focused on one of the Miami pilot project cases for public broadcast. Sarasota's project director was successful in getting Sarasota County to recognize infant mental health as one of the community priorities. The Pensacola site has trained all its comprehensive assessment providers on the pilot project assessment protocol. These are just a few of the many examples of increased community awareness.

Community awareness has also increased as a result of multiple presentations about the pilot project at local, state, national and even international conferences. Information about the pilot project (such as overall description of the project, goals and program design) has been presented at the National Association of Mental Health State Program Directors meeting in Miami, the Federal Interagency Coordinating Council meeting in Washington DC, the Zero to Three National Training Institute in Washington, DC, and the World Association of Infant Mental Health Congress in Amsterdam, to name a few examples.

Conclusion

Research has shown that increasing numbers of infants and toddlers are at risk for serious emotional and behavioral problems. Given the subsequent co-occurrence of these early signs of social emotional problems with later mental health problems (Degangi, et al, 2000), it is important to identify assessment and treatment strategies that will be effective with children during the critical window of early development.

Stopping abuse and neglect has untold value in the reduction of human suffering in the lives of the young children involved in this pilot project. In addition, given that the cost of abuse investigation and out-of-home care is estimated at $20,000 per child per year *(Florida Department of Children and Families),* the potential savings to the state in foster care costs for the 43 children who completed treatment and were reunified or had permanent placements could be estimated at $860,000 per year.

When infant mental health services are successful, an array of negative and costly consequences may be avoided. In addition to costs associated with the criminal justice system's response to a report of child abuse or neglect and the associated child welfare costs, the improved level of bonding and nurturance between the mother and child is thought to lead to better child development outcomes in all domains of development. The range of potential cost savings include reductions in health care costs, foster care costs, special education and criminal justice expenditures due to the cessation of further episodes of child abuse and neglect and improved interactions and relationships between the parent and child.

The assessment and treatment strategies used in the infant mental health pilot project were found to be effective in improving parent/child interaction and relationships, stopping abuse and neglect, and increasing reunification or permanent placements of children in foster care. Although the sample size was small, the findings are promising. However, they cannot be generalized to other populations, and the long term effectiveness of the project will require follow-up study.

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APPENDIX 1

Miami Infant and Young Children's Mental Health Pilot Project
Status Report as of June 30, 2003

A. The Miami Pilot Site

The Miami Infant and Young Children's Mental Health Pilot Project (IMH) for Year 3 continued to be a collaborative partnership between the Dependency Division of the Juvenile Court, Eleventh Judicial Circuit, and the University of Miami's Linda Ray Intervention Center (LRIC) with the expressed goal of providing a research-based model of dyadic therapy to a specific sample of maltreated toddlers and their primary caregivers who are under the auspices of the Dependency Court and the Department of Children and Families. The families in this Miami target population are among the hardest to engage in intervention services, often representing a group of mothers and fathers whose children have been removed from their care and placed permanently with relatives, or who have been in and out of the foster care system before returning home, or whose previous children were adopted when their parental rights were terminated. The Miami pilot sample was typically court-ordered into treatment with their young children, and chose the IMH program services upon the advice of their attorneys. Being court-ordered, however, does not automatically instill a motivation to participate in the clients, nor does it establish a sense of trust and/or a rapport with the mental health therapist and support staff at the onset. This rapport is built through extensive engagement activities on the part of the program staff with a goal of increasing compliance with the treatment plan from historically non-compliant parents. For some of the parents in the Miami project, the child participating with them in the IMH pilot program's dyadic therapy program was the first child of theirs to receive intervention services addressing mental health issues during the period of 1-3 years old, and this was probably the families first opportunity for them to try and heal the relationship with one of their children in a therapeutic program that was a best practice model of treatment.

Prior to the establishment of the IMH project in Miami three years ago, there were few if any services directed at parent-child dyads in the Dependency system with identified child maltreatment of children who were under the age of three years. A collaborative of community providers funded by the U.S. Dept. of Justice, Office of Juvenile Justice and Delinquency Prevention (*The Miami Safe Start Initiative*) mapped community resources for infant toddler mental health services in the Miami community in 2000 and did not identify any providers working with the 0-3 population who had a protocol for mental health evaluation or mental health services for children in this age range based on best practices. By targeting the court-involved population of parents with young children in this age range in Miami as the clients for the IMH Pilot Program, and utilizing the IMH research-based dyadic therapy and assessment model, a new opportunity became available for the Dependency Court and the Department of Children and Families to refer a small portion (10 dyads per year) of those highest risk families to the Miami IMH pilot program. It was anticipated that not only would the IMH Pilot program provide a way to put services in place for the underserved families, but that training in the best practice therapeutic model could be provided for a cadre of additional therapists who, in turn, could expand the community's ability to offer these services to a larger group of children 0-3 years old in the future, thereby effecting a systemic change in service delivery in Miami.

B. Summary Progress Report Narrative:
The Process of Referral, Evaluation and Treatment Coordination

Referrals and Evaluation
Division 02 of the Miami-Dade Juvenile Court continued to refer individual court cases of toddlers, adjudicated dependent, between the ages of 12-24 months with verified maltreatment or neglect charges, to the Linda Ray Intervention Center and it's collaborative partner, Archer Evaluations, Inc. for the initial and post-treatment PREVENT evaluations and the outpatient treatment. (See protocol attached to evaluation report) Upon receipt of the referral and a court-order for the initial PREVENT evaluation; Archer Evaluations, Inc. contacted the parent(s) and the DCF Family Services Counselor to schedule the evaluation. Two clinical psychologists completed the assessment protocol. Upon completion of the evaluation, Archer Evaluations passed copies of the PREVENT evaluation to the DCF Family Services Counselor, the Court and to the mental health therapists at Linda Ray who then continued with exhaustive engagement efforts to set up a schedule of home visits prior to the beginning of treatment, to meet with the parent to write a treatment plan, to schedule treatment sessions, arrange transportation services and to maintain collateral contacts during the treatment period, submitting reports to the court or appearing at court hearings to monitor progress. All completed written reports pre-treatment, during the treatment and post-treatment were submitted to the court to assist in rendering permanency decisions on behalf of the child.

In addition to dyadic therapy, recommendations were made by the therapists throughout the project period to DCF for supplementary services for the child based on observations made during the comprehensive evaluation and treatment sessions. (A number of the children were subsequently enrolled in Early Head Start and community childcare programs as a result of these efforts.)

Initially, the therapists visited the client's home or place of residence to outline the therapeutic program and to obtain informed consent (IRB#01/006) for the collection of data associated with the intervention. The model, incorporating home visits, was continued whenever feasible to establish contact and the "buy in" for the program services for new clients. This continued to allow for a less formal initial face-to-face contact by the therapist, and of course, gave a contextual framework from where the caregiver was operating, including the environment and the other family members or social connections that exist.

A treatment schedule for the ensuing 25 sessions which was most convenient for the client was established at the home visit, transportation arrangements were put in place and the participant incentive component was explained (i.e. Winn Dixie food vouchers, bus passes for Medicaid eligible clients) A food certificate was given at the beginning of treatment, at random treatment sessions and again, at approximately the halfway and completion marks. Clients have been most appreciative to receive these certificates. Once treatment was begun, the comfortable LRIC surroundings and staff interactions have promoted and encouraged clients to return for subsequent therapy sessions.

The infrastructure for this evaluation and intervention process had been put into place during Year 2 and the process was continuously honed in Year 3. Engagement activities to expedite the hand-

off process from evaluation to treatment completion were documented on a monthly basis. All required materials requested for audit purposes were submitted to DCF.

The following information summarizes the evaluation and intervention units for Year 3:
10 pre-evaluations for new clients were completed in Year 3.
11 post-tests were completed in Year 3.
254 units of dyadic therapy were completed in Year3.
A total of 361 indirect engagement hours were completed during Year 3.
A total of 720 direct engagement hours were completed during Year 3.
11 dyads completed treatment at the end of Year 3.
1 abuse report was made during Year 3 for dyads in treatment with no eventual findings. Child was temporarily removed, then reunified with mother.
100% of the families completing treatment during Year 3 were reunified with their children.

Treatment Coordination/Intervention and Implementation at Linda Ray Intervention Center

A high degree of organizational readiness and ability to maintain client participation has continued in Year 3 activities. Archer Evaluations, Inc. exhausted any and all strategies to schedule and complete the pre and post- evaluations and generate the reports for the LRIC therapist to create a treatment plan and to the court. At the intervention site, a number of activities devised during Year 1 & 2 continued to be utilized. The LRIC transportation van continued to pick up the caregiver and child regardless of whether they resided together or separately in Dade County and brought them to the therapy sessions. Caregivers with their own transportation were offered the same pick-up services, should they have been unable to come on their own any given week. By using the same familiar LRIC drivers (mature women from the community served) to pick up the clients, rapport has been extended between the clients and LRIC.

The Director of LRIC (in-kind) continued to be on hand for any after-hours intervention schedules to supervise any family members who accompany clients, to open and close the building, and to provide back-up support for any client issues that may arise during the therapy sessions. Fewer clients needed to be scheduled on Saturdays in Year 3 than in Years 1-2. University of Miami security remained available and close to the premises in the event they were needed. Questions or concerns about other aspects of client case plans requiring additional follow-up by the therapist or LRIC Director were handled. LRIC employees (in-kind) remained available during the week and for Saturdays in the event that a caregiver arrived with children besides the focus child, to provide supervision during the session.

C. Progress and Accomplishments

What changes occurred in the parent/child dyad following the interventions?

In addition to the analysis of change in the dyads conducted by the evaluators comparing pre and post-assessment quantitative data, it is important to also review examples of the qualitative, anecdotal record of changes seen in the parents and their toddlers as they carry on their day-to-day life activities, interacting in other arenas outside of the treatment room. In one particular case,

This is a single example illustrating how the integration of new behaviors, communication strategies and developmental progress of children become part of their daily life activities and supports the positive outcomes for the participating dyads.

Additional Outcomes

As previously mentioned, the initial inventory of available therapeutic services for children 0-3 had been compiled by the Linda Ray Project Director with representatives of community-based agencies, the MDCPS, and DCF as part of a companion project as part of the Miami Safe Start Initiative, funded to the Juvenile Court in partnership with the Linda Ray Center. That inventory revealed a scant number of agencies purporting to have therapeutic services available, and if so, services were targeted to children 3-5 years old. During the IMH Year 3 pilot activities, additional funds from other sources outside state appropriations were leveraged to increase the number of infant mental health therapists trained in the IMH best practice model of evaluation and dyadic therapy. Five additional therapists from Miami participated in a year-long IMH training for licensed therapists along with 23 therapists from West Palm Beach County as monthly trainings in West Palm Beach. Those five therapists represented agencies who have signed MLUs (Mutual Letters of Understanding) to provide dyadic therapy services to children 0-3 for the two years following completion of the training. Funding for the training participants tuition was leveraged from U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention funds for the Miami Safe Start Initiative. Additionally, during the Year 3 pilot period, DCF was able to set-aside funds to train an additional twenty licensed therapists from Dade County in the IMH model in a six month training institute model. Both of these training activities will ultimately create a larger number of trained therapists able to serve children 0-3 and their parents with the therapeutic model after the pilot program ends.

An additional component, primary medical care case management was added to the existing evaluation, assessment and treatment model for the Miami participants in the IMH pilot. The Linda Ray Center has employed a nurse practitioner to case manage the medical needs of the toddlers in the IMH program on an as-needed basis. Medical appointments were set, transportation provided by the Linda Ray Center for IMH families to the UM pediatric practice, follow-ups were scheduled and additional referrals to specialists were made. The nurse practitioner case-managed the families who chose this option to see that compliance with appointments was maximized. Every Thursday, the nurse practitioner, the therapist providing treatment and the Project Director reviewed the case status for IMH children as to compliance with services. This model had been shown to result in improved health status for high-risk toddlers at the Linda Ray Intervention Center and was therefore, expanded to the IMH cohort. This also provided a medical home at the University of Miami Dept. of Pediatrics/Community-based Medicine for parents who decided to choose UM as their Medipass Provider.

D. Case Study

Katrina

Katrina's son Charles was removed from her after Katrina ran away from her foster home and left Charles with her mother. Charles' father's identity was not known. During the initial observations of Katrina and Charles during their pre-treatment evaluation, minimal play was observed and for the most part, Katrina interpreted play as an opportunity to teach and lead her son. She did not willingly allow Charles to explore his environment or to initiate what play toys he wanted. Katrina's affect (facial expressions and body language) remained primarily neutral during the play period as she interacted with her son.

During Session 1 of the dyadic program Charles was observed to be quiet and seemingly withdrawn and frightened. Mother's interactions are limited and there is little communication between them.

Mid-way through the dyadic program (at Session 16,) Charles and Katrina play together with much more conversation, laughter and smiles, obviously showing pleasure in their play. Charles chose toys and talks about the objects and the game he wants to play and Katrina follows his lead and participates enthusiastically. Charles converses with the therapist and keeps up a steady stream of conversation throughout the session.

As the final sessions of the dyadic program continue the rapport and communication styles of Katrina and Charles continue to improve. Katrina and Charles are reunified in a foster home where Katrina can take on the responsibilities of caring for Charles under the guidance of a supportive foster mother. Over the next months, the foster mother will help Katrina and Charles plan for the next of the process, establishing a home for themselves as part of the Independent Living stage of reunification with support from DCF and the Charlee Program once Katrina turns 18 years old and completes her GED. She currently works for a local retail chain and will move to full-time once she completes her schooling. The dyadic therapy program and associated services have helped Katrina and Charles reach their goal of reunification.

Outcome: Mother/child relationship was improved, parental confidence increased, symptoms of depression in child decreased, and mother is living with her son in a supportive foster home. Child is attending Early Head Start, interacting well with peers and teachers and they are planning for the next stage, Independent Living, in the coming year.

E. Central Research Questions

1. *How sustainable are the interventions made with the parent-child dyads*?

Issues of sustainability were addressed in three ways by the Miami site as part of Year 3 activities. a) The University of Miami has been assigned a Medicaid number to provide clinical children's mental health services. A subsite code will be given to the Linda Ray Intervention Center program to fund assessments and treatment by the end of 2003 so that costs covered by Medicaid can be billed in the future for services. A second option, determining if the children in the target population meet Part C eligibility for services (under I.D.E.A.) and thereby being entitled to targeted case management services, could potentially cover engagement costs associated with outpatient treatment.

b) Collaborative partnerships have been cemented with Early Head Start for the provision of dyadic therapy treatment for a pilot group of EHS toddlers in the child welfare system, using federal appropriation dollars to contract with the Linda Ray Center for services. EHS's Child Welfare

Initiative funding was awarded to the Community Action Agency in Miami in January 2003. CAA is the agency in charge of Head Start and Early Head Start. Funding for the dyadic therapy component for EHSCWS for the Linda Ray Intervention Center is included in the federal dollars. Twenty four children from the Dependency Court system (a matched sample to the IMH toddlers) are enrolled at a South Dade EHS and will begin to receive dyadic therapy in May and June.

c) A third activity to sustain program services, the 18-month additional funding for the Miami Safe Start Initiative (U.S. Dept. of Justice, Office of Juvenile Justice and Delinquency Prevention) will continue until December 30, 2003. This helps Miami sustain the evaluation and treatment model for the target population in conjunction with EHS.

2. *What are the likely issues in replicating the initiative statewide*?

The IMH pre and post evaluations are thorough and comprehensive. Agencies may not be equipped to follow the assessment protocol in its entirety or may find the costs associated with these evaluations prohibitive even with Medicaid reimbursement.

Clinicians with credentials to provide dyadic therapy to children 0-3 are few. A concerted training and credential program would need to continue to be funded on a statewide basis to assure quality services to the target population using the model implemented in West Palm Beach and Miami during the Year 3 pilot period.

Services provided as in-kind in the current project might not be available at community-provider sites, thus driving up the costs of evaluation and intervention making it prohibitive to invest as much in the area of client engagement. Engagement activities, not funded by Medicaid may have to be reimbursed as targeted case management services as they are critical to keeping clients in treatment over time.

F. Barriers (Areas of Improvement)

The initially identified barriers to engaging the caregivers both in the evaluation process and the intervention have persisted to some degree between the project site at LRIC and associated service providers working the case. Gaining the necessary information from the DCF contacts remains an issue in Year 2. On the cases that have not proven to be consistent, there has frequently been a breakdown of communication on the part of DCF to provide extra support and pressure needed to keep the client compliant with the therapy appointments. The mental health counselor assigned to the courtroom from which referrals are received to help reach DCF counselors and contact the DCIP and LRIC staff, has had some success. On one or two occasions, however, program staff needed to enlist the presiding judge to pursue these contacts at a higher administrative level to inform them that line staff had not followed through. Sadly, one mother participating in the program passed away unexpectedly. The IMH staff received a call from the grandmother. It was the IMH staff that informed the DCF worker of the situation. The child was living jointly with the mother and grandmother, so a continuum of services was provided to the grandmother and the child after the mother's death by IMH staff for dyadic therapy and grief counseling.

As the end of Year 3 approaches, strategies for continuing infant mental health services at the Miami site are being put in place with various funding streams and with the expectation that additional identified revenue sources will fill in the gaps. Concurrent with the IMH project, the Miami site is a site for the federal Safe Start Initiative, funded by the Office of Juvenile Justice and Delinquency Prevention of the U.S. Department of Justice. In that capacity, Miami has received funding for a specialized Juvenile Court/University of Miami Early Head Start project. Maltreated toddlers, ages 12-36 months old, are enrolled at one of two specialized Early Head Start programs for early intervention. In addition, the child and primary caregiver participate in the identical dyadic therapy program formulated for the IMH project. Pre, post and mid-way assessments (PREVENT evaluations) for Safe Start toddlers correspond with the PREVENT evaluations for the IMH project. The OJJDP funding for the combined EHS/dyadic therapy program extends until December 2003 and represents the second round of funding for Miami Safe Start from OJJDP. Miami Safe Start dollars have also contributed to the Infant Mental Health Training in West Palm Beach, allowing 7 clinicians from Miami to participate in the year-long program. Mutual Letters of Agreement from the participants stipulate that they serve maltreated toddlers with dyadic therapy for two years following their completion of the training. This will help expand the program in Miami Dade County.

Leveraged with the Safe Start dollars from OJJDP are recurring federal funds from Head Start to the Miami District Community Action Agency under the recently appropriated Early Head Start Child Welfare Initiative (EHSCWS Initiative.) A joint proposal was written by the University of Miami and Early Head Start and the Juvenile Court and funded in January 2003 to serve additional toddlers 12-36 months old with identified maltreatment with EHS and dyadic therapy. The collaborative was one of 13 funding nationally and represents the only site presenting with a track-record of doing the 'work' for three years as part of IMH and for two previous years with OJJDP dollars.

In addition to federal dollars from Safe Start and EHSCWS, the University of Miami has recently completed the year-long process of obtaining a Medicaid number of infant mental health services. The University is currently putting internal systems in place so that each division of the University can have a site specific code and begin to use Medicaid for treatment and assessment. It is planned that the Linda Ray Center will have the necessary billing system to operationally begin Medicaid billing before the end of 2003 in addition to recurring federal dollars. That step will be necessary to take the system to a larger number of toddlers eligible for services at our University site.

In Miami, through a collaborative agreement with the District 11 Department of Children and Families, Florida State University, Louisiana State University and the University of Miami, a 6-month Infant Mental Health Training has been established. Twenty licensed clinicians representing DCF contracted agencies are being trained in the dyadic therapy model. It is planned that the clinicians will return to their agencies and begin to serve maltreated toddlers in their clinical practices at the end of the Training Institute in Miami Dade County with the IMH best practice model.

While the Safe Start and EHSCWS dollars do allow the project to continue with funding for the assessment, treatment and 'engagement' components, the reality of how to fund 'engagement'

time—time in Miami spent in follow-up with DCF family counselors, treatment specialists, attending court hearings, home visiting, maintaining telephone contact with clients—demands creative strategies to fill the gap that Medicaid ultimately does not cover. Engagement activities are essential to keep non-compliant, hard-to-reach clients in treatment and to maintain contact with the multiple service providers connected to the families in the Juvenile Court, Dependency system. Previous programs have failed to maintain client compliance with treatment, resulting ultimately in lower rates of program completion and lower rates of reunification of parents and children. The engagement connection is critical to insure hopes of more positive outcomes.

The Miami IMH partners are planning to pursue two immediate options: proposing a plan asking for engagement dollars from the Health Foundation of South Florida and from the School Readiness Coalition and ultimately the Children's Trust.

Since our local IMH and Safe Start projects have a strong University-based primary medical care case-management component it is hoped that the Health Foundation will want to extend the benefits with funding for continuation of that model of medical case management coupled with dollars which could be used for engagement for children's mental health services.

Last of our strategies at the Linda Ray Center site, is to move our IMH therapists to salaried positions with research dollars, thereby funding them to complete all aspects, assessments, treatment and engagement under the umbrella of the annual salaries.

Improving the Number of Completers of Treatment

It is apparent that a combination of all the above strategies will ultimately be necessary to maintain a continuum of quality infant mental health services for our target population throughout the state. Leveraging funds from additional sources will help us address the issues related to completers in the coming years which related to geographical proximity to the treatment site and progress of the cases through the judicial process.

Through the Early Head Start Child Welfare Initiative, the joint partnership between Linda Ray Center and Early Head Start, we were able to secure federal funding to open a South Dade Early Head Start site--Le Jardin-- for toddlers referred from the dependency system. Previously, it was difficult to serve those families referred from South Dade due to lack of transportation availability through DCF or too long a distance from South Dade to the Linda Ray Center in central Dade County. At Le Jardin, in Homestead, we have outfitted a therapy room in order to provide the dyadic therapy component. Our therapists travel to that site 2 days per week to meet needs of that community, complete pre and post assessments and provide outpatient treatment. We are now able to see those South Dade clients within their community and they are able to transport themselves and their children easily.

In order the expedite the timeline from referral to assessment to treatment, we have moved the assessments in-house as of the final months of Year 3. This will expedite not only completion of the PREVENT evaluations but will probably expedite timeline for writing of the reports and the treatment goals by having a one-stop assessment/treatment model in place. Our IRB Committee for Human Subjects Protection has recommended the move to complete services in-house in their last project review. Bringing services in-house cuts the processing time from referral to PREVENT to

treatment start-date and may increase completer numbers. Added to our ability to service South Dade we would expect serve more of the referred families in future project years.

It may behoove our program to target families with their first child in the system as we continue to hypothesize that those families are potentially more motivated to comply with treatment.

Fiscal Management

In Miami, fiscal administration continued to be maintained by the Administrative Office of the Court. However, at the state level OSCA (Office of State Court Administration) is no longer handling the contract funds disbursed by DCF to Miami. Instead, DCF must now disburse funds to the Miami-Dade County Board of County Commissioners. Both Jennie Rundell and Lynne Katz have been working to expedite the new system process and have faced hurdles during this current period. Additionally, at the state DCF level, Mr. Bithorn has been very willing to work with us to maintain our contract.

G. Training/Consulting/Dissemination

A critical aspect of the clinical intervention has been the oversight and supervision provided by Dr. Joy Osofsky to the 3 IMH sites. The West Palm Beach year-long Training Institute has provided clinical training to an additional five therapists from Miami-Dade County using federal dollars for their tuition. DCF's ability to provide additional training dollars for a six-month Training Institute has made it possible for twenty additional Miami licensed therapists to be trained in the IMH best practice model

Dissemination of program activities in Miami has occurred through community-wide presentations on the subject of infant and toddler mental health by the Project Director.

H. Miami Program Staff

Lynne Katz, Ed.D. has successfully maintained responsibility for the pilot program for Year 3. She has concurrently been the Director of the Linda Ray Intervention Program for substance-exposed infants and toddlers at the University of Miami for nine years and is also the Principal Investigator of the ongoing Miami Safe Start Initiative (DOJ,OJJDP) and the Strengthening Families Program (SAMHSA) at the Linda Ray Center.

Vanessa Archer, Ph.D. a psychologist in private practice for many years working with the Dependency system's population of families has provided clinical supervisor for Dr. Velasquez to complete the PREVENT evaluations.

Margarita Velazquez, Psy.D. A Psychological Examiner with seven years experience working with children and families completed pre and post evaluations in conjunction with Dr. Archer.

Silvia McBride, LMHC is the Program Therapist; she has eight years experience interacting with children between the ages of 0-5. She delivers dyadic therapy to the participants.

Saribel Ceballos, Pediatric Nurse Practitioner (in-kind) has provided primary medical care case management as needed under the direction of the University of Miami's Dept. of Pediatrics for families who have chosen UM as their Medipass provider.

Angelika Claussen, Ph.D. is the Research Coordinator for LRIC as well as for the Safe Start Initiative and has provided IMH linkages with the LSU cross-site evaluation team for Year 3 data (in-kind).

Jennie Rundell, (AOC Grants Administrator) provides administrative support for the program (in-kind) and manages fiscal operations in conjunction with Dr. Katz.

I. Recommendations

A high degree of administrative tasks and oversight related to the program activities continues to be required. A considerable amount of time has been expended in the planning and implementation phases as well as the on-going maintenance phase. In future contracts, this should be addressed as a potential consideration for administrative time to be factored into the project budget.

Perhaps the primary recommendation from the Miami site which has served court-ordered, hard to engage families for three years would be the recommendation for future agencies serving this highest risk group would be to target parents with their first child in the Dependency system. We hypothesize that those parents may have a higher degree of motivation to participate in treatment rather than risk losing their first baby 'to the system.' Additionally, since the target child would be their first child in the Dependency system they may require less engagement to stay compliant with the dyadic therapy program and thereby increase their chances for reunification and permanency with their child. Getting in early as they start their family and providing intervention could also serve as prevention deterrent for any additional children from that family coming into the system in the future.

1. What supports and services have been found to be the most needed, and most used by the centers and families that used them?

Childcare access and primary medical care needs are the presenting services most needed. Housing issues also are at the forefront of much-needed client services. The Miami IMH project has established linkages with Head Start/Early Head Start and Child Development Services to put these services in place. Safe housing continues to be lacking in the Miami community.

2. What unforeseen problems have emerged in implementation, and what changes might be made to the original plan?

The evaluation protocol is being reviewed to determine to what degree the measures can tease out the progress of the dyads over time. Additionally, discussions about the possibility of widening the age range of children who could receive services are being discussed.

As the end of Year 3 approaches, strategies for continuing infant mental health services at the Miami site are being put in place with various funding streams and with the expectation that additional identified revenue sources will fill in the gaps. Concurrent with the IMH project, the

Miami site is a site for the federal Safe Start Initiative, funded by the Office of Juvenile Justice and Delinquency Prevention of the U.S. Department of Justice. In that capacity, Miami has received funding for a specialized Juvenile Court/University of Miami Early Head Start project. Maltreated toddlers, ages 12-36 months old, are enrolled at one of two specialized Early Head Start programs for early intervention. In addition, the child and primary caregiver participate in the identical dyadic therapy program formulated for the IMH project. Pre, post and mid-way assessments (PREVENT evaluations) for Safe Start toddlers correspond with the PREVENT evaluations for the IMH project. The OJJDP funding for the combined EHS/dyadic therapy program extends until December 2003 and represents the second round of funding for Miami Safe Start from OJJDP. Miami Safe Start dollars have also contributed to the Infant Mental Health Training in West Palm Beach, allowing 7 clinicians from Miami to participate in the year-long program. Mutual Letters of Agreement from the participants stipulate that they serve maltreated toddlers with dyadic therapy for two years following their completion of the training. This will help expand the program in Miami Dade County.

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multiple service providers connected to the families in the Juvenile Court, Dependency system. Previous programs have failed to maintain client compliance with treatment, resulting ultimately in lower rates of program completion and lower rates of reunification of parents and children. The engagement connection is critical to insure hopes of more positive outcomes.

The Miami IMH partners are planning to pursue two immediate options: proposing a plan asking for engagement dollars from the Health Foundation of South Florida and from the School Readiness Coalition and ultimately the Children's Trust. Investment option strategies for funding of Infant/Toddler mental health services have been proposed to the Children's Trust Board during the month of April for review over the next few months.

Since our local IMH and Safe Start projects have a strong University-based primary medical care case-management component it is hoped that the Health Foundation will want to extend the benefits with funding for continuation of that model of medical case management coupled with dollars which could be used for engagement for children's mental health services.

Last of our strategies at the Linda Ray Center site, is the move towards having our IMH therapists become salaried positions using research dollars to support their costs and targeted case management dollars from Part C, to complete all aspects of assessments, treatment and engagement under the umbrella of the annual salaries.

It is apparent that a combination of all the above strategies will ultimately be necessary to maintain a continuum of quality infant mental health services for our target population throughout the state.

During Year 3, the Miami IMH site was featured on National Public Radio's program "All Things Considered." Information about the IMH project was also featured on the NPR website, including the critical clinical supervision and guidance offered by Dr. Joy Osofsky, Louisiana State University. (www.npr.org and at www.miamisafestart.org)

Multiple presentations about the Miami IMH project have been made at both the state and local levels including: Child Welfare League of America (Washington, D.C.), Zero to Three's Birth to Three Institute (Washington, D.C.,) Child Trends (Washington, D.C.) and the State Mental Health Network (Orlando and Tampa.)

APPENDIX 2

INFANT MENTAL HEALTH PILOT PROJECT
PENSACOLA LAKEVIEW CENTER
YEAR END REPORT
June 2003

The Pensacola Pilot Site

The Pensacola Pilot Site is located at Lakeview Center, Inc. a comprehensive Mental Health Center located in the panhandle of Florida. Lakeview has approximately 1900 employees and serves approximately 27,000 clients in the various programs and locations. These numbers include the Protective Supervision and foster care system for District One (Families First Network), which came under the direction of Lakeview Center a year after the Pilot began. Lakeview has offered in-patient, day treatment and outpatient services for close to 40 years. Services to children under 5 have been limited prior to the introduction of Infant Mental Health.

SUMMARY PROGRESS REPORT

The Infant Mental Health Pilot Project in Pensacola continues to follow the protocol established in January 2001. Referrals received from the Department of Children and Families are staffed with the caseworker prior to contact with the family. All families voluntarily register as clients of Lakeview Center, the community mental health center affiliated with Baptist Health Care. All Assessments are videotaped at LCI following the criteria established January 2001. Specific tools include Ages and Stages Questionnaire, Background information and Pediatric Intake (psychosocial), Beck Depression Inventory, Parenting Stress Index and The Crowell Tool Task which involves the parent relating to the baby in varied predetermined situations (i.e. Free play, cleaning up, performing a developmentally difficult task, separation and reunion, etc.). 25 pre assessments have occurred to date.

Treatment continues to be provided predominantly in the homes due to transportation issues. When possible, a session will be videotaped at LCI. Treatment initially focuses on the parent/child relationship but also includes parent education, individual therapy for the mother and family therapy if indicated. Parents with significant mental health or substance abuse issues are encouraged to seek treatment outside the project. Twelve dyads have completed treatment (8 available for post assessment), five dyads dropped out for various reasons (jailed, moved, job interfered with scheduling) and 8 continue to be active.

Post assessments have occurred as families complete treatment. Dyads are once again videotaped as they participate in the Crowell. A Beck and PSI are also administered. An End of Treatment Interview occurs to gather data from both the parent and therapist as to perceptions of the effect of treatment on child's behavior, dyad's relationship, and mother's emotional well-being. Eight post assessments have been completed.

PROGRESS AND ACCOMPLISHMENTS

During the past 2-½ years, the Pensacola community has been exposed to Infant Mental Health. During the first year, Sandra Lee and Pam Carr made a power point presentation to the Chief Judges Children's Task Force educating them on Florida's Strategic Plan for IMH as well as sharing about the Pilot. The presentation was also made with Lakeview Center's Board of Directors. The Children's Services Center brought Sandee Adams to Pensacola for a two-day conference to educate clinicians, parents, and others in the community. The second day focused on forming an IMH Initiative (work group) to address implementing the goals of the Strategic Plan in our community (District One which includes Escambia, Santa Rosa, Walton and Okaloosa Counties). Three ongoing workgroups formed to address Prevention, Intervention, and Steering (funding, PR, etc.). The Initiative meets quarterly to discuss activities occurring within each workgroup. The "Infant Mental Health Initiative" brought Florida IMH therapist Myra McPherson to Pensacola to do a day and a half workshop for Home Visitors including therapists in April of this year. Networking and planning for trainings for each of the 3 levels of IMH services continues to be the focus of the Initiative.

Lakeview Center, Inc. developed a 0 to 5 sub-committee from the Clinical Practice Committee to establish protocols for expanding services and educating the LCI community to this population once the research Pilot was completed.

District One ADM representative, Rodney Moore worked with the undersigned and the above mentioned committee to establish a protocol and training (Feb. 26, 2003) for the therapists who perform Comprehensive Behavioral Assessments on children 0 to 5 who are removed from their homes. The Pilot procedures served as a model for that Protocol.

Some accomplishments within the pilot have been captured as data in the post assessment exercises. They include improved relationship between dyad as reflected in the Crowell, and less depression and stress as reported by mother. Some accomplishments may be subtler yet equally if not more meaningful to the people involved.

For example, Tasha (name changed), aged 22, has 6 children under the age of seven. She lives in a unairconditioned 3-bedroom apartment in public housing. She had no telephone or means of transportation except boarding the bus with 6 children in tow. The family had been under Protective Supervision for some time due to reported neglect (the youngest was injured while in the care of a 13 year old uncle). Her third child met criteria for the Pilot. Mother allowed me in her home but was cold and defensive. She only talked to me in direct response to a question. She "barked" at her children who responded promptly to her commands. She appeared depressed although she reported low scores on the Beck. Treatment was provided in the home as well as "in the van" as we worked together to develop our relationship and improve her standard of living. Tasha became more open as she shared about her harsh childhood. A couple of years earlier she had been diagnosed as depressed, placed on medication but did not follow through with the

traditional means of treatment. Her relationship with her children has improved as she has learned other ways to relate to them. The pilot case was closed with D. J. but our work continues as a case was opened with his 19-month-old brother. Tasha continues to be under Protective Supervision as she makes poor choices that put her children at risk (tested positive for a prescribed pain killer not prescribed to her) resulting in removal of the children from her care and placing them with their grandmother. At this point, Tasha followed the recommendation of the undersigned by admitting herself to a Crisis Stabilization Unit for a week. She received medication treatment for her depression and anxiety, which helped her mood and attitude in relating to family members as well as her caseworkers. Her parenting style and relationship with her children are slowly showing improvement. She seems to enjoy them more and value their individuality. She has been willing to place them in daycare and encourage their learning. She has found employment in housekeeping but wants to continue her education to get her GED.

CENTRAL RESEARCH QUESTIONS

The pilot interventions focus on improving the relationship between the mother and the baby. The skills achieved by the mother should generalize to relationships with her other children as well as other relationships in her life. She will have incorporated basic concepts into her repertoire of relating.

Two additional goals of the Pilot included reunification and no further substantiated abuse reports. Although none of the clients involved in the pilot had additional abuse reports, 1 mother mentioned earlier in the report tested positive for a prescription painkiller not prescribed to her resulting in violating conditions of her case plan. Three families of active or completed cases have reunified during treatment and two of the currently active cases anticipate reunification in June. All of the completed cases reunified and had the case plans closed.

AREAS OF IMPROVEMENT

Transportation continues to be an issue with the families physically getting to the Center for treatment. Home visits aide the therapist in seeing issues that need to be addressed without having to rely on the mother to share concerns about home. Assess to videotaping and having the boundaries of one room at the Center with no outside distractions has another advantage. No shows during scheduled home visits continue to be an inconvenience as well as a waste of therapist's time.

TRAINING AND DISSEMINATION

During the past 2-½ years, the pilot staff met 3 times in Miami for training, supervision and reassessing the program. Various in-services were provided at the Two Building Our Future Conferences. Dr. Bob Harmon held a two-day training on DC 0-3. Four Lakeview Center staff in addition to Pam Carr attended the training. Sandee Adams and Myra McPherson presented IMH Training for early intervention providers in Pensacola in August 2001. Myra returned in April 2003 for further Level 2 and 3 training. Joy

Osofsky and her staff at LSU/HSC in New Orleans provided supervision and training for all 3 pilot sites on 3 occasions. She provided all day training in Pensacola open to 100 local clinicians in December 2002.

Additional training provided in Pensacola included SEDNET sponsored monthly 2 hour lectures on such topics as "Surviving Court", domestic violence, Mental status Exam, cognitive behavioral therapy, and infant attachment/adult resilience, child sexual abuse, adolescent sex offenders, substance abuse, women's depression, etc. Lakeview Center offered a daylong workshop on assisting survivors of sexual violence.

Pam Carr was asked by the Guardian Ad Litem director to speak with the new class of GALs during their training March 15. As a result, the director joined the IMH initiative and has been an active member.

RECOMMENDATIONS

Sandra Lee and Pam Carr are working with the Clinical Practice Committee at Lakeview to continue and expand the program once the pilot has been completed. The issue of funding will follow the guidelines of the agency as Lakeview has the Access Behavioral Health Care contract. We anticipate referrals coming through the Protective Service workers (FFN) as well as the therapists performing the Comprehensive Assessments for District 1 ADM.

We anticipate continuation of the pre assessment phase with the Ages and Stages, Crowell tasks, Beck and PSI. The Clinical Practice Committee is developing a psychosocial that meets the requirements of our various accrediting agencies. Due to the cost in time and travel, home visits will be limited to some degree with clinic visits being a priority.

Community involvement and collaboration with other agencies such as the Health Department, Healthy Families, Children's Service Center, FFN, Court facilitation, guardian ad litem program, etc. continues to be important in providing services to this population as well as support to the service providers including the undersigned.

The following comments and recommendations are from Sandra Lee, Director of Specialized Children's services:

- Lakeview Center currently operates under Access Behavioral Healthcare (ie: prepaid mental health plan) therefore direct billing to Medicaid does not apply for our agency/district. IMH program cost will be budgeted within carve-out revenues/expenses.

- Lakeview Center is committed to providing IMH services as modeled under the IMH pilot project. Pam Carr will continue as primary therapist , however services will be expanded to include the 0-5 population.

- Several training sessions have been conducted within the district on IMH pilot project, assessment protocols, DC 0-3 and treatment models. All district providers of Comprehensive Assessments (C.A.) have been trained in 0-5 assessment needs/protocols. Currently exploring funding opportunities with ADM to be treatment provider for C.A. referrals.

- Lakeview Center is lead agency for district child welfare community-based care programs and will be a primary/priority referral source due to high incidence of abuse/neglect in this population.

-Lakeview therapist will coordinate treatment needs with children's case managers for specialized and/or targeted case management needs.

- Exploration of IMH growth in regards to expansion of "specialized" therapists as need warrants

Considerations/Recommendation for State expansion:

- Expansion of Medicaid billing(fee for service) is recommended to include "engagement" activities as defined by "pilot" project. Much time is spent on engagement activities in establishing rapport and engaging clients into treatment .

- Expand caps on # of individual/family therapy and ITOS services.

-Require "comprehensive assessments" to include all components of "pilot" assessments/protocols and/or increase reimbursement rates for 0-5 assessments as they require increased amount of time to complete (versus psycho social or in-depth assessment). Explore a certification/utilization of "pilot" assessment to replace C.A. for 0-5 and/or create equitable levels of reimbursement.

PROJECT STAFF

Pam Carr, MSW continues to be the clinician for the Infant Mental Health Project at Lakeview Center, Inc. in Pensacola. She has provided clinical services to children and their families through Lakeview Center since August 1981. Sandra Lee, LMHC, the Director of Specialized Children Services of which IMH is a reporting unit, is the supervisor. Ms. Lee reports to Ann Bernard and Dennis Goodspeed, who report to Dr. John Bilbrey, Director of Adult and Child Development Services. Dr. Morris Eady, "founder" and Executive Director of Lakeview Center, an affiliate of Baptist Health Care retired this year. His successor is Gary Bembry. Lakeview Center programs provide mental health and substance abuse treatment for children and adults in outpatient as well as residential programs.

APPENDIX 3

Sarasota Infant Mental Health Pilot Project
Status Report as of June 30, 2003

A. The Sarasota Pilot Site:

The Sarasota Infant Mental Health Pilot Project (IMH) for Year 3 has continued to provide a high level of engagement, assessment, and treatment services to high risk infants and their families. The IMH pilot project has allowed our agency to provide a research-based model of dyadic therapy to a sample number of infants and toddlers and their parent(s) at risk for attachment disorders and other mental health conditions. The children/families in this target population were largely children from the foster care system with the goal of reunification with their parent or ones recently reunified with their birth mothers as a result of completion of their case plan. Other families involved in treatment were referred from Healthy Families, Early Intervention Program, or First Step Mother's and Infants Program (a substance abuse treatment program for pregnant mother's). All dyads in the pilot were considered to be at high risk for abuse/neglect, domestic violence, substance abuse or relapse, delayed child emotional development, or mental health disorders. Services provided through the IMH pilot were primarily voluntary in nature with a few exceptions of court ordered treatment.

Prior to the initiation and funding for the Infant Mental Health pilot project three years ago, there were few, if any mental health services available for children under the age of five years and their parents/caregivers in Sarasota County. The pilot project has increased awareness in our community of the need for identification and treatment intervention with young children and their parents/caregivers and an understanding that intervening early in a child's life is not only life altering but also cost effective.

B. Summary Progress Report Narrative:
The Process of Referral, Evaluation and Treatment Coordination:

Referrals and Evaluation:

Child Development Center has continued to receive referrals from the Partnership for Safe Families, Healthy Start, Healthy Families, First Step and various area agencies. Most of the children were between the ages of 12–36 months of age with histories of abuse, neglect and maltreatment. Children referred from the Mother's and Infant's Program at First Step were newborn or a few months of age who had pre-natal exposure to alcohol and substances. The IMH pilot project coordinator completed the initial evaluation, pre-test and diagnostic evaluation, treatment planning, all dyadic treatment interventions and post test evaluation. Referrals were made when appropriate for Speech, Occupational and Physical therapy. Mothers with serious depression or other mental health issues were referred for Individual therapy when necessary. Home visits and daycare visits were made

frequently for further assessment and/or when transportation was an issue for the families involved. Written progress reports were provided to case-managers at the Partnership for Safe Families regularly to assist in permanency planning on behalf of a child.

Initially, the child and parent/caregiver visited the CDC offices to complete the intake procedure, outline the Infant Mental Health therapeutic program and obtain the informed consent (IRB#01/006) for the collection of data associated with the Infant Mental Health Pilot Project. The IMH therapist would make home visits and/ or daycare visits for further assessment and intervention services. Dyadic treatment was provided one to two times weekly for one to one and a half-hours either at the CDC offices or on-site. The number of visits recommended by the pilot project is 25; however, more or less number of visits were considered on an individual basis.

This evaluation and intervention process was established in Year 1 and continued for the duration of the IMH pilot project. Engagement activities from evaluation to completion of treatment were documented on a monthly basis. Indirect engagement activities continued to take much of the time spent during Year 3, as it had in the previous two years.

The following information summarizes the evaluation and intervention units for Year 3 :

35 referrals were made for new clients
13 pre-assessments for new clients were completed
13 post-assessments were completed
421 units of dyadic therapy were completed
A total of 602 engagement hours were completed
13 dyads completed treatment
0 abuse reports were made in Year 3
8 children were reunified with their natural mothers
2 children were not reunified with their parents and went to Long Term Relative Care with family members

<u>Treatment Coordination/Intervention and Implementation at Child Development Center</u>

Treatment coordination/intervention in Year 3 continued to be a challenge in maintaining client participation, particularly with court ordered participants from the foster care system. Court ordered parents involved in the reunification process initially were resistant to dyadic treatment. From the development of a positive therapeutic relationship with a strengths-based focus, many of the participants improved parenting skills and bonding/attachment with their babies. Transportation services were provided by case-managers from the Partnership for Safe Children for children in the foster care system. Voluntary clients who did not have transportation were given on-site services whenever necessary. Evening hours of appointments were added for the convenience of several working parents.

One advantage of our pilot site is that both mental health services and child welfare services are under the direction of the Vice President of Community Based Services. The

Vice President also provided the direct clinical supervision and administrative over-sight of the IMH pilot project. This central oversight of both programs allows for a higher degree of coordination, collaboration, and conflict resolution with involved cases.

C. Progress and Accomplishments

What changes occurred in the parent/child dyad following the interventions?

The most positive change that occurred following IMH interventions was the mother's increased ability in interpreting the child's verbal/nonverbal cues and responding accordingly. Communication skills between the dyads improved as parent/caregivers learned to follow the child's lead in play and increased their understanding of age appropriate developmental milestones. The resulting increase in bonding/attachment that occurred supports the positive outcomes for the participating dyads.

Additional Outcomes

The IMH pilot project allows the therapist to address multiple parental issues that affect the child in a safe contextual framework of the therapeutic process that benefits both the parent and the child. Therapists at Child Development Center have attended Infant Mental Health training by Dr. Joy Osofsky. This training will ultimately assist the therapists in identifying those dyads most at risk for bonding/attachment issues, and increase the number of 0-3 children and their parents receiving treatment with the IMH best practice model.

D. Case Study

Reese

Reese was removed from his mother's care soon after birth due to her history of substance abuse and incarceration. Reese was placed in a foster home where there were many other children and his needs were not met. Reese was removed from that foster care home and at 9 months of age, was placed with a pre-adoptive/foster care couple. Reese had very sad, flat affect and was experiencing night terrors, eating problems and sleeping problems, and his speech was slow. During the initial observations of Reese with his pre-adoptive/foster mother, Cassandra, he appeared to play in a randomly forced manner, did not smile and made very little eye contact.

During session 1 of the dyadic program, Cassandra was consistently engaged with him; however, he did not respond in a natural way or smile. Reese's interactions were limited and his manner was tenuous, at best.

Mid-way through the dyadic program (at session 12) Reese plays more attentively and interacts with Cassandra .She follows his lead in play and engages him with much enthusiasm. Reese has begun to smile and make eye contact more consistently and is having fewer night terrors. At one point, Reese reaches toward the therapist and initiates a hug, warmly and enthusiastically. Cassandra and the therapist observe this as indicative of Reese's increasing ability to connect with trust to another person.

As the final sessions of the dyadic program continue, the dyad makes progress in their communication and Reese's speech improves. Cassandra's gentle reassurance, consistency and warmth promote a sense of trust and safety for Reese. Cassandra's increased awareness of developmental stages and ability to set firm limits with positive reinforcements helped Reese to feel secure with her and others. His night terrors have decreased and his eating and sleeping improved.

Outcome: Parent/child relationship was improved, parental confidence improved, child's trust level increased, symptoms of depression in child decreased and affect improved significantly. Reese's eating and sleeping problems decreased. Adoption was eminent at the time treatment ended.

E. Central Research Questions

1. How sustainable are the interventions made with parent-child dyads?

(a) Sustainability was addressed at the Sarasota pilot site as Year 3 ended. Dyads who completed treatment have maintained their level of functioning without relapse or re-involvement in the child protection system. Parent(s) gained a significant degree of trust in both the agency therapist and the organization and have stated they would become re-involved in treatment in the future if they felt there was regression in their child, themselves, or the relationship.

2. How sustainable are the services provided through the IMH pilot project?

(a) Sustainability of the intensive services provided through the pilot project are a work in progress. Changes made in AHCA policy regarding assessment and treatment of the 0 through 5 population has increased our ability to bill Medicaid for assessment and treatment services. Our agency's creation of a crosswalk from the DC: 0-3 diagnostic manual to the ICD-9-CM and its acceptance by AHCA has made it possible to provide mental health services to the 0-3 population and receive Medicaid reimbursement for these services. Under current Medicaid services, ITOS (Intensive Therapeutic On-Site) services could sustain the level of treatment provided in the pilot project. However, with the initiation of pre-authorization for these services, it has made it more difficult for agencies to acquire an adequate number of treatment hours and have

the therapist time to go through the pre-authorization process. This pre-authorization has limited us in providing treatment. There are currently no services in the Medicaid handbook that would allow us to bill Engagement services. All pilot sites have concurred that these services are critical to enrolling and maintaining families in treatment. Through an ADM contract/funding, these services could be billed under the Outreach cost center. In addition, our agency is actively pursuing local funding through the county, private funders, and local community foundations to continue the high level of assessment, engagement and treatment services provided through the pilot model. We have been able to secure a donation of $25,000 from an anonymous donor to date.

(b) Our agency has provided intensive infant mental health training to all the mental health therapists at our agency in order to expand the number of clients we can serve. In addition, all eligible therapists are in the process of certification for provision of Comprehensive Behavioral Health Assessments. This particular assessment will allow us to maintain the quality of the assessment protocol established in the pilot project.

(c) The existing relationship Child Development Center has with the Partnership for Safe Children (our Community Based Care Program), Healthy Families, Healthy Start, Early Intervention Program, and First Step's Mother's and Infant's Program has strengthened since the implementation of the Infant Mental Health pilot project and will continue after Year 3. Future collaboration with Head Start/Early Head Start is in the beginning stages. Our agency has recently taken the lead in the development of the Suncoast Chapter of the Infant Mental Health Task Force, involving the four counties of Sarasota, Manatee, DeSoto, and Charlotte. A community breakfast for all community stakeholders is in the planning process. In addition, the Director of the IMH pilot and Vice President of CDC was a member of our local planning group SCOPE (Sarasota County Openly Plans for Excellence) studying the issue of mental health in our community. As a result of her involvement, presentation, and advocacy, the SCOPE study group report to the community will recommend county funding for continued training and treatment services for infants and young children. Child Development Center is striving to be a leader in the mental health service delivery system for infants and young children and their families in Sarasota, surrounding counties, and the state of Florida.

F. Barriers (Areas of Improvement)

Client transportation issues continued to be a barrier for Year 3 at Sarasota as well as engaging caregivers in the evaluation and intervention IMH process. Child Development Center has coordinated with area service providers such as Partnership for Safe Families, Healthy Families, Healthy Start, and First Step's, Mother's and Infant's Program for excellent referrals. The intensity required for the coordination of these services and increased communication between the agencies is an integral part of raising community awareness of the profound impact of early experience on the 0 to 5 population.

The benefits of the IMH treatment model continues to represent a cost effective prevention/intervention program that is critical in meeting the needs of high-risk infants

and their parents, despite the lack of state and federal funds currently available for these services.

G. Training/Counseling/Dissemination

The training and supervision provided by Dr. Joy Osofsky to the 3 IMH pilot sites has been instrumental to the success of the pilot project. Kathryn Shea, LCSW, and Vice President at Child Development Center is taking the lead in the development of the Suncoast Chapter Infant Mental Health Task Force for Sarasota, Manatee, De Soto and Charlotte counties. She has provided training at the local and state level during the past three pilot years in order to educate and disseminate information critical to policy and treatment initiatives. Kela Miller, LCSW, Infant Mental Health Pilot Project Coordinator has facilitated IMH presentations to area agencies and service providers to promote community awareness.

H. Sarasota Program Staff

Kathryn Shea, LCSW and Vice President of Community Based Services at Child Development Center maintained clinical and administrative responsibility for the pilot program during Year 3. Kathryn directs all Outpatient Mental Health Services, Behavioral Support Services, and Community Based Care Case Management and Adoption services for Sarasota, Manatee, and DeSoto counties for the birth through five population. Kathryn has nearly 25 years experience in mental health services.

Kela Miller, LCSW, is the IMH Pilot Project Coordinator and clinician for the Infant Mental Health pilot project at Child Development Center in Sarasota, Florida. Kela reports to Kathryn Shea, LCSW, IMH pilot administrator and CDC Vice President for Clinical and Community Based Services.

I. Recommendations

The expansion of the Infant Mental Health pilot project to provide services to all families with children 0 through 5 years old, concentrating on educational awareness and integration into Early Head Start and Head Start programs is recommended. The expansion of Infant Mental Health to programs that serve disadvantaged children and teen mothers would be advantageous. Mothers with developmental delays could benefit from Infant Mental Health services, as few services are available. Foster parents need to be more educated and involved in case planning and reunification efforts. Future training for therapists and case-managers on the identification and treatment of Infant Mental Health issues to enhance their skills could help to improve school readiness for more children. Finally, education of local, state, and federal policy makers on the importance of primary prevention as a cost-effective program with Infant Mental Health could help to ensure funding for future generations.

1. What supports and services have been found to be the most needed, and most used by the centers and families that used them?

   Housing needs, WIC, childcare and primary medical care services are the most needed by clients at the Sarasota site. Referrals and linkages to Head Start/Early Head Start, Early Childhood Education, Early Intervention Programs and Individual mental health services (including psychiatric) for parent's/caregivers are also needed by the families. Engagement services provided by the IMH therapist was critical to the pilot success and involvement and completion of treatment by the pilot dyads. This service is typically not funded nor re-imbursed by any insurance company, including Medicaid, and yet without it, we would not have witnessed the positive outcomes we see.

2. What unforeseen problems have emerged in implementation, and what changes might be made to the original plan?

   As mentioned previously, more timely provision of collateral treatment (adult mental health, substance abuse and domestic violence services) for parents is desperately needed in this community. Services for clients without Medicaid or other insurance is critically needed as an increasing number of families are joining the work force and are no longer eligible for Medicaid, yet cannot afford other health insurance. Although our agency has a sliding fee scale, we cannot operate an outpatient mental health program with a high number of sliding fee scale clients. In addition, there is no reimbursement for the administrative oversight, paperwork requirements, outcome measurement requirements, or certification/regulation requirements in the provision of mental health services. This makes it extremely difficult to operate a program and stay within funding limits.

   Additional barriers include resistance in clients, primarily in the dependency cases, to treatment or dishonest reporting their mental health status that can affect treatment outcomes. Mother's with developmental delays may need more time for assessment, treatment, and engagement services, thus affecting cost/time measurement. Pre-adoptive children may have missing background information that could be vital to the treatment modality of the dyad. Case plan requirements of dependency cases can sometimes be overwhelming to parent's of very young children thus reducing the number of dyads that complete treatment.

All of the above mentioned interventions on a community level indicate a move toward sustainability of the Infant Mental Health pilot project. It will take the combination of these and other strategies to support the future provision of infant mental services.