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Accessibility and Reliability of Early Childhood Mental Health Services

by

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The purpose of this study was to determine whether early childhood mental health services are accessible and reliable in rural northeast Iowa. Qualitative interviews were conducted with seven professionals who work with children aged three to five that have mental health needs. Nine themes were developed: (a) Believed Causes of Early Childhood Mental Health, (b) Reasons for Referral, (c) Definition of Reliable, (d) Available Resources and Limitations, (e) Barriers to Early Childhood Mental Health, (f) Location is Key: Rural Communities and the School, (g) Caregiver Mental Health and Perception, (h) Family Approach in Early Childhood Mental Health and (i) More Training, More Professionals. The findings of this study suggest while resources may be reliable, accessibility to such services is problematic because of numerous barriers such as lack of transportation, awareness and available mental health professionals. The findings also indicate a need for more professional development and training and sensitivity to the needs of small, rural communities. While this study is exploratory in nature, it holds implications for social work practice, policy and future research.

Keywords: early childhood mental health, reliability, accessibility, barriers

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Accessibility and Reliability of Early Childhood Mental Health Services

Early childhood mental health is a rising concern among human services professionals. Up to 22% of school age children have mental health problems and yet less than one quarter access professional services (Oh, 2014). Disruptive behavior disorders affect at least 10% of children and are the most common reason for a mental health referral (Muntz, 2004). Research shows that addressing mental health concerns at an early age is more successful than trying to reverse the effects of traumatic experiences as an adult (Dickstein, 2015; Muntz, Hutchings, Edwards, Hounsome & O'Ceilleachair, 2004). While infant mental health is not new to social work, it has only been in the last 10 years or so that early childhood mental health has really garnered attention for being important to the well-being of children (Stone, 2012). Early childhood mental health is typically defined as work in the mental health field with children from birth to age five (Carrey, Curran, Green, Nolan, & McLuckie, 2014; Dickstein, 2015; Essex et al., 2009). For the purposes of this study, early childhood mental health is defined as work in the mental health field with children aged three to five.

With so many young children experiencing mental health issues, it is no longer acceptable to adopt a "wait and see" attitude, or that it is "just behavior" (Carrey et al., 2014). If these issues are not addressed at a young age, it is likely to become a life-long health concern that will affect a child's ability to be successful and prosper as an adult (Carrey et al., 2014). Evidence shows that infants and young children experience intense psychological distress, which can have long-term consequences (Carrey et al., 2014; Dickstein, 2015; Essex et al., 2009). Lack of accessibility or reliability of services that address these concerns is problematic as it leaves children and families with little to no

support. The result is that these children continue to grow and learn at a vulnerable age, when the appropriate intervention could have a profound impact, and yet little to nothing is available (Dickstein, 2015; Mental Health Weekly, 2005; Carrey et al., 2014). This study defines accessibility as the ability of parents, caregivers and other services providers of young children to locate and participate in available community resources for children with mental health needs. This includes whether these people 1) have knowledge about available services, 2) know about and can navigate the referral process, and 3) can afford available services. For the purposes of this study, reliability of services is defined as a service provided by competent, well-trained employees with knowledge and experience in working with early childhood mental health services, which are consistent, dependable and effective.

Practitioners in the field of social work, including clinicians, agency workers and in-home providers are routinely faced with mental health concerns regarding infants and toddlers and are not equipped with the proper knowledge or education to respond adequately (Mental Health Weekly, 2005; Stone, 2012).   These professionals are left with minimal training received through their employment, but must rely on their own instincts for what the best course of action may be when trying to speak to solutions for parents and families (Larrieu & Dickson, 2009; Stone, 2012). This can create an unease of working with small children in the mental health arena, as practitioners in the field are uncomfortable with their education and knowledge (Larrieu & Dickson, 2009; Stone, 2012). Social workers may choose to decline working with this population for fear they do not have the appropriate tools to affect change.

Infant mental health can offer a practitioner a variety of assessment and intervention methods to help understand and engage with families of infants and very young children, allowing a therapist or social worker to work with a population they would have declined to serve in the past (Tomlin & Viehweg, 2003).

The purpose of this qualitative research project is to determine whether early childhood mental health services are accessible and reliable in rural northeast Iowa. In this study, the following research question will be examined: Are early childhood mental health services accessible and reliable? The data will be collected through interviews with professionals who have experience working with young children with mental health needs, aged three to five. The data collected will provide valuable insight to the world of human services, including social workers, psychologists and other human service professionals. The findings regarding accessibility and reliability of services in this field may provide valuable information on improving existing programs and making considerations for the creation of new approaches and services.

Literature Review

This research project is designed to answer the question: Are early childhood mental health services accessible and reliable? This literature review will discuss the following themes: a) the definition and therapy approach for early childhood mental health, b) the prevalence of mental health in young children, c) the importance of adequate, reliable services, d) training in early childhood mental health and e) services available to families.

Early Childhood Mental Health

Definition. Early childhood mental health describes work in the mental health field with children from birth to age five, while infant mental health relates to working with children from birth to age three (Carrey et al., 2014; Cousins, 2013; Dickstein, 2015; Essex et al., 2009; Tomlin & Viehweg, 2003). In the late 1970s, the impact of childhood experiences was recognized as important and within the last 10 years, research for early brain development has supported this theory (Tomlin & Viehweg, 2003). Selma Fraiberg and her group created the term *infant mental health* to describe their work with children ages zero to two (Tomlin & Viehweg, 2003). Studies support the idea that healthy attachments of children to their caregivers creates a healthy start to a child's life and gives that child a greater chance of success later in life (Cousins, 2013; Dickstein, 2015; Tomlin & Viehweg, 2003).

> Infant and early childhood mental health is defined as:
>
> The young child's capacity to experience, regulate and express emotions; form close and secure interpersonal relationships; explore and act on the environment and learn…(that is) best accomplished within the context of the caregiving environment that includes family, community and cultural expectations (Dickstein, 2015, p. 488).

Preschool age children engage in exploring their environment, developing self-awareness and self-regulation (Elias, 1998). This is a time for rapid memory, language and cognitive skill development (Elias, 1998). All development is integrally related to each other and what happens in one area of development will have an affect on another (Elias, 1998).

Parent-child relationship. The wellbeing of a young child is determined by the relationship the child has formed with the parent or caregiver (Cousins, 2013). When that relationship is healthy and loving, it assists the child's mental health being positive and well developed (Cousins, 2013). When children experience neglect, a different relationship is formed between parent and child, resulting in fear, listlessness, aggression and insecurity (Cousins, 2013; Dickstein, 2015; Macdonald et al., 2005). Neglect is not only the failure to meet a child's basic physical needs, but also the persistent failure to meet the child's psychological needs, including unresponsiveness to the child's basic emotional needs (Cousins, 2013).

Therapy Approach

Because children rely on healthy attachments, with secure and close relationships, therapy approaches when working with infants and young children focuses on the parent-child relationship (Cousins, 2013; Dickstein, 2015; Tomlin & Viehweg, 2003). The parent-child relationship is central to healthy development (Dickstein, 2015; Larrieu & Dickson, 2009). Therapists must consider the needs of the parents and the needs of the children simultaneously (Tomlin & Viehweg, 2003). This creates a broad spectrum of necessary services in order to best service this clientele, including mental health promotion in communities and relationship-based prevention strategies which are typically provided by in-home workers, not clinical social workers or psychotherapists (Tomlin & Viehweg, 2003).

Interventions have a greater chance of success if parents are ready to engage and participate in therapy or other mental health services (Berger & Umaschi, 2011; Edlefsen & Baird, 1994). The Individuals with Disabilities Education Act (IDEA) identifies

family intervention as a vital component in mandated early intervention services for preschool children who are at risk of developing disabilities or delays in communication, cognitive, social, emotional, physical or adaptive development (Bates, 2005). Parents that are not yet engaged have a higher rate of poor attendance, poor adherence to programs, and premature termination of services (Berger & Umaschi, 2011; Bates, 2005).

Prevalence of Mental Health Challenges in Young Children

When children experience emotional neglect in early childhood, those children become more susceptible to anxiety, depression, anger and aggression both in childhood and later as an adult (Cousins, 2013; Giannakopoulos et al., 2014). Mental health is a substantial health issue, affecting up to 22% of school-age children internationally and in the U.S. (Oh, 2014). The National Health Interview Survey surveyed 1499 children 4-5 years old. Of this sample, 8.5% were estimated to have mental health issues but of those 131 children, only 9 use any mental health services in the prior year (Muntz, 2004). The same study suggests 7.5 million children have an unmet need for mental health services in the U.S. An estimated 8-21% of preschool-aged children have difficulty with social-emotional expectations, about half of which have tend to continue as those children get older (Oh, 2014). Very young children can exhibit negative mental health symptoms and disorders. Problems in preschool can predict anxiety disorders, depression, and aggression or delinquency later in life (Oh, 2014). Young children can still experience grief; sadness, anger and hopelessness, just like an older child or an adult (Dickstein, 2015). Current studies suggest preschoolers experience common psychiatric disorders at a rate similar to older children, consisting of behavior and emotional problems (Giannakopoulos et al., 2014). Nearly one in seven children will experience a mental

health disorder. When left untreated, up to fifty percent of preschool problems will continue into later childhood (Giannakopoulos et al., 2014).

Behaviors of preschool age children can be difficult to separate between problematic behaviors that are concerning and those negative behaviors considered developmentally appropriate (Elias, 1998). Approximately 10-20 percent of preschool age children show negative behaviors that are not in the realm of "normal" developmental expectations in terms of frequency, intensity and persistence (Elias, 1998). About half of the students in preschool that have identified problem behaviors continue to display significant problems during the school age years (Elias, 1998). Historically, there is a general assumption that preschool age children would outgrow problematic behaviors and so were less likely to draw attention from mental health professionals (Elias, 1998).

Importance of Adequate, Reliable Services

Assessing and identifying mental health disorders in young children creates an opportunity to pair these children with resources specific to their need. Intervention during the preschool years has been shown to have a cost-effective impact on developmental outcomes, compared to interventions in later childhood or as an adult (Giannakopoulos et al., 2014). Muntz determined that in England the long-term economic impact on society for unresolved mental health disorders could exceed 1 million pounds for a single individual over their lifetime (2004). Early intervention has the potential to reduce future problems for young children (Oh, 2014).

Barriers. Families struggling to find mental health services for their children will find the system fragmented and complex, making it difficult to access appropriate care (Bringewatt & Gershoff, 2010). The National Survey of American Families shows that

of the children needing mental health care, only twenty-one percent actually receive such services (Kataoka, Zhang, & Wells, 2002; Bringewatt & Gershoff, 2010). While research shows early childhood mental health services are important to the wellbeing of young children, federal funding levels do not reflect this need as a priority (Bringewatt & Gershoff, 2010). The Substance Abuse and Mental Health Services Administration (SAMHSA) spent over $4.2 billion on residential treatment in 2002 and only $400 million on community-based mental health in 2005 (Bringewatt & Gershoff, 2010).

Aside from funding concerns, other barriers to accessing care include the stigma surrounding mental health (Corrigan, 2004; Bringewatt & Gershoff, 2010). Because of the stigma mental illness carries, mental health issues are often criminalized, such as when police respond to a mental health crisis instead of the mental health system (Corrigan, 2004). Other barriers include lack of information about available services, knowledge on when it is appropriate to seek care, a distrust of the "system," limitations on insurance coverage, shortages of services available, and difficulty accessing services (Bringewatt & Gershoff, 2010). A prevailing theme through the literature is the lack of information regarding what services are available, how to access these services and when and how to seek help for children in need of mental health services (Bringewatt & Gershoff, 2010; Giannokopoulos et al., 2014; Edlefsen & Baird, 1994).

Training in Early Childhood Mental Health

Training in infant mental health first began in 1973 when the Michigan Department of Mental Health commissioned the University of Michigan Child Development Project to provide clinical training to twenty-four mental health clinicians, under the direction of Fraiberg (Stone, 2012). Training consisted of seminars,

individualized learning, clinical experiences and clinical supervision (Stone, 2012).

Currently, no specific training is required to work in early childhood mental health.

There is no specific national licensure or certification to document expertise in this field

(Tomlin & Viehweg, 2003). Initiatives, such as the one in Virginia, are starting to

emerge. The training initiative in Virginia is aimed at clinicians, treatment providers and

case managers, introducing therapists to approaches for treating major mental health

disorders in infants while other professionals learn about infant/toddler social-emotional

development and mental health needs and how they can support those needs (Mental

Health Weekly, 2005). Many early intervention services consist of "generalists" such as

early childhood professionals and other non-therapist professionals (Muntz, 2004).

Findings from studies indicate that clinicians and therapists are continuing their

education in the realm of early childhood mental health due to internal motivation rather

than licensure or certification requirements (Stone, 2012; Virmani, Masyn, Thompson,

Conners-Burrow, & Mansell, 2013). These professionals revise and improve their

knowledge, skills and attitudes to be effective with their clients, especially if the

continued education can be integrated with the current strategies of the therapist (Stone,

2012).

The literature suggests that while not all human service professionals receive

training in early childhood mental health, many such professionals seek it out on their

own accord, seeing it as a personal responsibility to their practice (Stone, 2012;

DeNatale, 2013). A teacher's understanding and belief in the mental health system is

critical to the referral process, especially in early childhood education as that teacher is

typically the first person to identify a need for special services (Edlefsen & Baird, 1994).

Professionals who complete screenings, assessments or referrals must be familiar with the needs of very young children as these children may not display typical symptoms of mental health issues (Williams et al., 2012).

Professionals not trained in ECMH are not as equipped to handle mental health needs of young children and are less likely to make appropriate referrals to mental health services (Virmani et al., 2013; Giannakopoulos et al., 2014). Williams et al. (2012) notes that after training clinicians and modifying clinic procedures and processes, significant improvements were seen in service linkage with young children. Clinicians trained in early childhood mental health have been found to provide more appropriate referrals that led to higher rates of mental health service delivery than those who are untrained (Williams et al., 2012). Connecting young children with mental health services is a difficult process, especially without appropriate training (Williams et al., 2012). A primary problem identified by non-therapists is finding pediatric therapists (Muntz, 2004). Without such professionals (in both urban and rural communities) therapy costs rise, resulting in less therapy than desired by families and services staff (Muntz, 2004).

Larrieu and Dickson (2009) describe a model of training in infant mental health offered by two separate medical facilities. The trainees of these models come into the program with previous education and training in another field including social work and psychology, but with a focus on the adult or parent in a relationship. Trainees admit that switching focus to the perspective and needs of the child instead of the parent can be overwhelming as it was never a standard practice in earlier training or experience (Larrieu & Dickson, 2009). Given the literature reviewed, it is unclear as to whether the training in the area of early childhood mental health is considered adequate or necessary.

Services Available to Families

The mental health service system lacks an overarching policy requiring services for all children. Instead there is mix of policies that have been developed in fields other than mental health, including education, child welfare and juvenile justice systems (Bringewatt & Gershoff, 2010). Many policies are adopted from adult mental health (Bringewatt & Gershoff, 2010).

How services are accessed. Accessing services comes down to two options: 1) a parent seeks mental health services for their child or 2) someone from another agency or organization makes a referral for mental health services for the child. Referrals may come from schools, community health centers, private insurance, Medicaid or the State Children's Health Insurance Program (CHIP), home visiting, assertive community outreach, residential support, the child welfare system and the juvenile justice system (Bringewatt & Gershoff, 2010; Macdonald et al., 2005).

The most common setting for referrals is the school with 70-80% of children receiving services doing so in school settings (Bringewatt & Gershoff, 2010). Review of studies in early childhood mental health shows mental health services are under-utilized for preschool aged children with emotional and behavioral problems (Elias, 1998). With so many of these children in community based preschool classrooms, preschool teachers are an important link between families and access to mental health services (Elias, 1998). Many preschools have a process in place for making referrals based on a ranking system of the importance of the problem behaviors exhibited by the preschooler.

The child welfare system and the juvenile justice system have become the de facto mental health service providers (Bringewatt & Gershoff, 2010). Of the children in

the child welfare system, half of these children have mental health problems; the same is true for more than 2/3 of children in the juvenile justice system (Bringewatt & Gershoff, 2010). The ideal system would be that of "no wrong door" (Williams, Perrigo, Banda, Matic, & Goldfarb, 2013). This concept is based on the idea that the appropriate referral and linkage to services would be provided, regardless of where the referral originated (Williams, Perrigo et al., 2013). The U.S. Department of Health and Human Services Center for Substance Abuse Treatment (CSAT) developed this concept so that people with co-occurring substance abuse and mental health problems could receive appropriate care regardless of who they contacted first (2000).

In regards to early childhood mental health, there is frequent co-occurrence of developmental and behavioral challenges. A "no wrong door" policy would allow families to seek help from many types of agencies including developmental, educational, mental health or medical services (Williams, Perrigo et al., 2013).

Types of services offered. Federal mandates require states to provide special needs screening programs for preschool children (Elias, 1998). When behavioral or emotional problems occur outside the academic setting, they are less likely to be addressed by the school system (Elias, 1998). Elias elaborates on this idea with an example of bias in special needs referral and identification processes. In a secondary study, Head Start teachers almost always identified students with significant behavior or emotional problems as their main concern for special needs, and yet, the majority was not formally identified for special needs services (Elias, 1998).

Mental health services offered in early childhood can be diverse, provided by many different professionals in a variety of locations, including home, community and

hospital settings, and with various funding sources (Macdonald et al., 2005). Schools

often provide mental health assessments, behavior management consultation and crisis

management (Bringewatt & Gershoff, 2010). Schools also offer referrals to specialized

programs, individual counseling, case management, and group counseling. These

services are often offered by other agencies as well (Bringewatt & Gershoff, 2010).

Other types of services include mentoring, transportation, medication monitoring, in-

home treatment and individual, group and family therapy (Bringewatt & Gershoff, 2010;

McWilliam, Harville, & Young, 1996; Cousins, 2013; Giannakopoulos et al., 2014;

Stone, 2012). The system of care approach focuses on collaboration among agencies to

provide accessible, community-based services in the least restrictive environment

available (Bringewatt & Gershoff, 2010).

Effectiveness of programs. Even with effective programming, much depends on

family engagement and cooperation (Oh, 2014; Axford, 2009). For children aged 3-17,

mental health service utilization was low (Muntz, 2004). The rate of use is even lower

for preschool children at 2-3% of 3-5 year olds accessing services (Muntz, 2004).

According to the study conducted by Oh, of the toddlers and young children in need of

services, no services were sought from specialist mental health professionals (2014). The

majority of parents did not seek any kind of program or services, 38-45% of parents

sought help from informal services and 7-8% sought help from general health

professionals (Oh, 2014). Professional services appear to be underutilized in comparison

to needs in the community when targeting early childhood mental health services (Oh,

2014). Parents' perception of mental health challenges is vital to both accessing and

utilizing available services. (Oh, 2014). Parents who seek services for themselves may be

more likely to find services for their children, particularly because the health professionals treating the family have more opportunity to ask about family functioning and recognize concerns regarding any children (Oh, 2014).

Program style. Program styles can play an important role in the approach to therapy or services in early childhood mental health. Two distinct styles or approaches focus on 1) needs and 2) rights of the children (Axford, 2009). Need is defined as whether the child's health or development has been impaired or will likely become impaired in the absence of remedial services (Axford, 2009). A needs-based approach utilizes many different types of services, thinking of the individual instead of the "one size fits all approach." This approach based on individual circumstances, making services subjective and a little more personal (Axford, 2009).

The right's based approach is another style, defined as a claim to be treated in a certain way (Axford, 2009). This approach identifies procedures and standards intended to dictate the conduct of individuals and other organizations (Axford, 2009). This typically highlights a legal entitlement (Axford, 2009).   Using a rights approach means the others with the same complaint are treated the same, with less subjectivity (Axford, 2009).   Many times these two approaches are at odds with one another. Services and programs designed to meet the child's needs are not always desirable including distressing therapy sessions or harsh routines to resolve behavioral problems (Axford, 2009). A rights-based approach may overlook the need for affection and warmth towards clients. The wishes of the service user may determine what interventions are used and may not address the true need of the client (Axford, 2009).

If clients and service providers can recognize these styles can exist in conflict with one another, it is possible to minimize the tension that is created and implement policies and practices that accomplish harmony between services (Axford, 2009). Congruency in services would have 1) interventions that are designed to be effective in preventing or alleviating a specific problem, 2) the intervention would accurately target clients – reaching those children with the target problem, 3) the program compliments other programs but does not hinder or create additional problems and 4) the program may also prevent or alleviate additional problems on top of the initial targeted problem (Axford, 2009). Axford's theory is that the "center of gravity" of children's services will shift based on the strength of the factors shaping public policy (2009).

Limitations of available services. While there appears to be a plethora of programs designed to serve young children and parents, there are many shortcomings (Macdonald et al., 2005; Elias, 1998; Williams, Perrigo et al., 2013). Earlier it was discussed that to achieve successful outcomes, parental involvement in early childhood mental health services is vital (Tomlin & Viehweg, 2003; Dickstein, 2015; Larrieu & Dickson, 2009; Berger & Umaschi, 2011; Bates, 2005). Many times the needs of parents and children are addressed by different interventions, with only a select few jointly addressing the needs of parents and their children (Macdonald et al., 2005). Parent-child attachment or infant social-emotional development is rarely the reason for referral or interventions (Macdonald et al., 2005). In many communities, early childhood mental health services are a part of another resource and only referrals for children who are considered at high levels of risk are accepted (Oh, 2014). This can make it difficult for families to access necessary services. Other barriers identified by administrators working

in early childhood mental health included high caseloads, long gaps while hiring new therapists, and lack of master's level professionals in the field (Muntz, 2004). Without the needed therapists, demand is greater than what is available, causing therapists to see as many children as possible, decreasing the amount of time spent with each client. This stretches the therapist's ability to provide the needed high-quality therapy to children (Muntz, 2004).

Among the limitations cited by professionals in the mental health services field, was shortage of funding and resources, as well as the lack of necessary training and skills (Macdonald et al., 2005; Bringewatt & Gershoff, 2010). Services are fragmented with little to no coordination between with other agencies and lack of continuity over time (Macdonald et al., 2005). Elias (1998) observed that the DSM-IV diagnostic system had limited application to preschool age children. Most studies conducted to develop diagnosis under the DSM-IV were based on samples of school age children and adolescents (Elias, 1998). Without clear-cut cases of extensive developmental disorders, there are no adequate standards to help a mental health provider consider a child's developmental context when deciphering the behaviors of very young children (Elias, 1998).

Mental health professionals also identified concerns for accessing mental health services. Providers felt that lengthy waiting lists, lack of comprehensive services for multi-needs families, gaps in antenatal/postnatal care prohibiting effective observation of parents and infants were all limitations in available care (Macdonald et al., 2005). Many identified funding restrictions and deficits in resources and training. Providers also

attributed gaps in service delivery to poorly coordinated and integrated services, with lack of interagency connections and collaboration (Macdonald et al., 2005).

        Looking to the future. Research indicates that mental health professionals need to look towards prevention, early identification and intervention in early childhood (Macdonald et al., 2005). Improved access to services and an increase in the mode of service delivery including easily reached locations, a greater range of service delivery options and culturally sensitive programs (Macdonald et al., 2005). Collaboration and integration of service delivery options to better organize available services is necessary, including networking, information sharing, joint training, clear referral pathways, and continuity of treatment over time (Macdonald et al., 2005). Improved integration between child welfare and mental health agencies will lead to more services for youth and mental health improvement (Williams et al., 2012). Parent education on who to talk to and where to search for services, as well as education on the benefits of treatment could improve engagement and use of community resources (Oh, 2014). Helping families gain familiarity with different referral processes and creating positive experiences with services could be beneficial in increasing service use (Oh, 2014). Ways to improve on the issues of training and availability of therapists include increasing the number of training positions at universities, as well as expanding financial support to programs to increase training and offer additional therapy hours (Muntz, 2004). Finally, the importance of training and integration of clinicians in the mental health service system was identified as a necessity, as those trained in early childhood mental health are more equipped to recognize and appropriately refer children with mental health needs (Williams et al., 2012). As mentioned previously, services and interventions made

available or created are largely determined and shaped by public policy and those factors

that influence policy – is it a rights or a needs perspective (Axford, 2009)?

Overall, this study will add to the available research on early childhood mental

health services by examining the available services and the resulting effectiveness and

reliability of these services. Practitioners are faced with dilemmas of how to treat early

childhood mental health needs effectively. With an increasing prevalence of young

children experiencing mental health problems, adequate and reliable resources are

important. In this study, qualitative interviews will be conducted with community

professionals, such as caseworkers, preschool and kindergarten teachers, mental health

therapists, and special education specialists, working with young children with mental

health needs. In the following section, the conceptual framework will be examined.

Conceptual Framework

This study will be examined using a family systems theory perspective. The

family systems theory identifies the nuclear family, not the individual, as the emotional

unit (Dickstein, 2015; Gilbert, 2006). Two primary concepts are present: 1) whatever

affects one affects each one within the system and 2) family members experience fusion

of themselves into the family to create a greater whole (Gilbert, 2006). This means that

individuals cannot be understood on their own, but rather as an entire unit, impacting the

lives of the members of the family (Dickstein, 2015; Gilbert, 2006). The family systems

theory is utilized because struggles in early childhood mental health affect the family as a

whole, not just the child. Dickstein writes:

…(I)t is considered that (1) child development occurs in the context of multiple

levels of relational systems (e.g., parent-child, parent-parent, family unit) that

impinge on each other; (2) not only do children change, grow, and develop over

time but also family systems themselves experience transitions in structure,

resources, and routines; and (3) when stressed, the complex accumulation of risk

factors affects early development as well as (and perhaps through) family

functioning (2015, p. 489).

As research notes, early childhood mental health has a specific focus on the

parent-child relationship and whether the child has formed a healthy attachment to the

caregiver (Cousins, 2013; Dickstein, 2015; Tomlin & Viehweg, 2003). When

determining what services are necessary for a child struggling with mental health issues,

the child's mental well-being cannot be considered on it's own, the mental well-being of

the caregiver is also considered because poor parental mental health can impact the child

(Cousins, 2013; Tomlin & Viehweg, 2003; Dickstein, 2015). A family system identifies a

distinct role for each person in the family, which then creates an interlocking unit. Roles

are based on behaviors expected from the person in specific social situations

(Hutchinson, 2011). In family systems theory, when one member of the family

experiences an event, that experience is transferred throughout the family and

experienced by everyone (Gilbert 2006).

When a child experiences a struggle in mental health, the caregivers and other

members of the family unit feel the effects (Gilbert, 2006). Sometimes there is a shift in

roles because of changes experienced by the child. If a child is struggling with their

mental health and it requires the constant attention of the mother, the mother's role in the

family may change. She may have previously taken on the role of caregiver for the entire

family but can now only focus on the child. A shift has occurred within the family

system and the unit as a whole feels the difference (Hutchinson, 2011; Gilbert 2006). The same idea can be applied if a parent is experiencing difficulty, leaving the parent unable to properly care for their children. The roles have shifted because the parent is consumed by something else, potentially leaving the child without someone to step into the role of caregiver. Attachment to the parent becomes strained, which in turn may cause anxiety, depression, and attachment issues in the child (Tomlin & Viehweg, 2003). Family anxiety can lead to "triangling" where one parent brings anxiety into the unit (Gilbert, 2006). The anxiety is passed from one parent to the other, and causing the first parent to calm down. The anxiety is then passed on to the children. If this occurs frequently enough, the child will develop physical, mental, emotional or social symptoms (Gilbert 2006). This anxiety the family is continuously experiencing overpowers a thoughtful response and logic is inaccessible, which keeps the relationships of the unit unresolved and anxiety will continue to increase (Gilbert, 2003). When parents and caregivers are unable to find and access resources to address the mental health needs of the child or the parent and child relationship, the family structure is left continuously experiencing that anxiety or fragmentation and members of the family are unable to function as a unit. When services are accessible and reliable, the needs of the different members of the family unit can be addressed and, potentially allowing those members to return to healthier functioning within the family, reducing stress and anxiety and allowing healthier relationships and attachments within the family.

Attachment theory will also be used when conducting this study. Attachment is characterized by specific behaviors in children, such as seeking proximity with a primary caregiver when experiencing fear or insecurity (Bowlby, 1988). Children can be

described as having secure, insecure or disorganized attachments to caregivers (Siegel, 2012; Bowlby, 1988) Securely attached children are able to explore their environment, relying on the caregiver when upset or afraid; engage in positive peer interaction and function socially and emotionally (Siegel, 2012; Bowlby, 1988). Children with insecure attachments avoid the caregiver, with less interaction between caregiver and child, and do not seek comfort from the caregiver when afraid. These children struggle to explore and play (Bowlby, 1988). The style of attachment is a good indication of future success in school and life, as well as a predictor of later psychopathology (Siegel, 2012).

A child needs healthy attachments to at least one primary caregiver for successful social and emotional development and regulation of feelings (Bowlby, 1988). Following the evolutionary theory of attachment, as developed by Bowlby, it is known that children come into the world pre-programmed to form attachments with others as a means of survival (1988). They use indicators like crying and smiling to elicit innate responses in caregivers such as comfort, care and responsiveness to the infant's needs (Bowlby, 1988). This attachment relationship is the foundation on which all future social relationships are built; therefore, a disrupted attachment can have severe consequences (Bowlby, 1988). The most critical period for attachment is from birth to five years of age (Bowlby, 1988). If a parent struggles with a mental health illness, it is much less likely that he or she can appropriately respond to the needs of the child, potentially hindering a healthy attachment. Likewise, if a child suffers from mental illness, the child may not give the appropriate cues to receive the care he or she needs (Siegel, 2012). Without this give and take in the relationship, unhealthy or insecure attachments may be formed (Siegel, 2012; Bowlby, 1988). Many infant and early childhood mental health services focus on the

parent-child relationship and the importance of attachment. With healthy attachments come healthier minds (Cousins, 2013; Dickstein, 2015; Tomlin & Viewhweg, 2003). When services are accessible, parents may be more likely to utilize these resources and if services are reliable, it gives greater opportunities for the focus of the work to be building and rebuilding healthy attachments between parents and children, directly influencing the mental health needs of the child (Cousins, 2013; Dickstein, 2015).

When family systems theory and attachment theory are intertwined, a picture emerges of the necessity for healthy relationships to be formed, which require healthy minds and bodies (Gilbert, 2003; Bowlby, 1988; Siegel, 2012). If a parent is not able to fulfill the traditional role of caregiver to the child, an insecure attachment is formed (Bowlby, 1988). The parent may have shifted into a different role and cannot provide for the needs of the child (Gilbert, 2003).

Methods

Research Design

The purpose of this study was to examine early childhood mental health services to determine if those services are accessible and reliable. The research was qualitative in design, utilizing semi-structured, open-ended interviews of professionals working with young children and mental health services. Qualitative research uses accounts from different people to address a research problem. Analyzing the data brought meaning and helped to understand the question posed in the research (Monette, Sullivan, DeJong, & Hilton, 2014).

This study also used grounded theory to help develop theory from the data. Grounded theory allowed the researcher to develop additional concepts not previously identified (Monette et al., 2014).

Sample

For this study, seven professionals were selected using criterion sampling (Monette et al., 2014), based on experience working with children aged three to five who have mental health needs including mental health counselors, preschool and kindergarten teachers, Area Education Agency 267 providers (special education specialists), and teen parent educators. The researcher hoped participants would represent a broad spectrum of individuals working with children with mental health needs, with a varying level of experience and expertise in the field. These professionals were selected from the surrounding rural towns and communities in northeast Iowa. Email and phone calls were used to invite individuals to participate in the study. A script (Appendix A) was used, to maintain consistency in the method of recruitment. The recruitment email was sent directly to the potential study participants. If no responses were received within two weeks, the researcher sent a second email to a second set of professionals. The time and place of the interview was discussed and determined with the participant when the researcher identified potential participants. Study participants were also recruited using snowball sampling (Monette et al., 2014), after receiving contact information from current study participants. These professionals were recruited through the same means as the original set of study participants.

Protection of Human Subjects

In order to ensure the protection of human participants, an informed consent form was used with each participant (Appendix B). The consent form was reviewed and signed with each participant prior to the interview, further detailing the purpose of the study, the voluntary nature of the study, and measures that were used to ensure confidentiality. This form was reviewed and approved by the chair of the researcher, as well as the St. Catherine University Institutional Review Board. Participants were given time to ask questions or express concerns regarding the consent form or any details relating to the study. The researcher asked the participants if the interview could be audio recorded and that such recording would remain confidential and would be destroyed after completion of the study on May 31, 2016. The researcher explained that the purpose of the audio recording was to review and present the findings to colleagues for peer-review. This study was conducted under the supervision of Dr. Catherine Marrs Fuchsel. If any participant had questions or concerns regarding the study, they were encouraged to contact the Human Subjects Institutional Review Board through St. Catherine University.

Data Collection Instrument and Process

Data was collected using semi-structured, open-ended interviews, completed in person. A schedule of questions was developed (Appendix C). Open-ended, flexible questions allowed the participants to more freely discuss and express their experiences (Monette et al., 2014). Participants were first asked about available resources in early childhood mental health. Participants were then asked about which resources the participant felt were most reliable. Questions became more specific, asking reasons for referral, services available within the schools, and the types of diagnostic tools available

in early childhood mental health. Some questions asked during the interview included:
Which resources do you feel are the most reliable? What do you consider reliable? What are the implications of lack of accessible or reliable early childhood mental health services? What are some of the barriers you have observed to accessing resources? Where do you see improvement for early childhood mental health? What are the diagnostic tools used in early childhood mental health?

Interviews were 40-70 minutes in length and were audio-recorded and then transcribed. These transcriptions were then coded to identify categories and themes in the data. This information was then protected in a locked file in the researcher's home and saved under password protection on the researcher's laptop.

Data Analysis Plan

Once the interviews were completed, the researcher transcribed the audio recording verbatim. Open coding and content analysis was used to identify codes and themes within the study. Open-ended coding was used to find ideas that appear within the data and were used to create themes. Grounded theory was also used during coding in order to help identify themes.

Validity and Reliability

A colleague reviewed and performed a reliability check of coding for the researcher to ensure themes were accurate and complete. This colleague signed a confidentiality agreement related to the coding of transcribed interviews. The researcher, the researcher's committee and the researcher's colleague reviewed interview questions to ensure validity and reliability. Themes discovered during coding were linked to themes

found in the literature to determine similarities and differences between the data and the

literature review.

Strengths and Limitations

This study sought to understand and explore the available resource options for

young children experiencing mental health challenges and their families. This study used

the subjective experiences of community professionals that work with young children and

have experience with early childhood mental health issues and needs. Because research

on early childhood mental health services is a more recent focus in the mental health

arena, available literature is more limited. Infant mental health has been studied more

extensively while early childhood mental health has received less attention. The field of

social work benefits from this study as it provides additional literature and research into

accessibility and reliability of early childhood mental health services, identifying

common gaps and barriers and increasing knowledge of appropriate resources for

families and their children, as well as practitioners working with this population. This

research is important to the field of social work as it relates to working with children, at

an early age where potential interventions could have a dramatic impact on their future

mental health, addressing these needs at a young age instead of as an adult. This

qualitative study gave a real voice to those who work in this field. The researcher of this

study has had personal experience navigating the world of mental health services for

young children, allowing an understanding of the challenges children and parents face

when trying to identify and connect with possible resources.

Personal experience of the researcher may also be a limitation of the study. This

may have created the possibility of researcher bias. To limit researcher bias, the

researcher reviewed interview questions, codes and themes identified with the research chair and with a colleague. Lack of knowledge and understanding surrounding early childhood mental health may have been an additional limitation. With only a few months to complete interviews, transcribe, and code the data, lack of time was a limitation. Another limitation was sample size. This study interviewed seven participants, giving a somewhat narrow, subjective lens through which available resources are discussed.

Findings

In this section, the characteristics of participants will be discussed as well as the findings of the study based on the study participants' responses. Ten major themes were discovered across seven different interviews with professionals working with young children and early childhood mental health services. The ten major themes identified in this study include (a) Believed Causes of Early Childhood Mental Health, (b) Reasons for Referral, (c) Definition of Reliable, (d) Available Resources and Limitations, (e) Barriers to Early Childhood Mental Health, (f) Location is Key: Rural Communities and the School, (g) Caregiver Mental Health and Perception, (h) Family Approach in Early Childhood Mental Health and (i) More Training and More Professionals. In order to protect the identities of participants and maintain confidentiality, participants were assigned names. The names assigned to the participants were the following: a) Amy, b) Beth, c) Cassie, d) Dawn, e) Emily, f) Fay and g) Grace. Seven interviews were conducted with seven participants who were identified as professionals working with children aged 3 to 5 and early child mental health services. Two participants were teachers, two participants were mental health providers and three participants were community agency professionals. All participants interviewed by the researcher were

female. Two participants had education and work experience in education and early childhood development and behavior. Five participants had education and work experience in the social sciences. The experiences of these professionals varied in setting, services offered and position held. The researcher will now present the ten major themes that emerged in this study.

Believed Causes of Early Childhood Mental Health

Five out of seven study participants recognized environment, family dynamics and parenting skills as chief causes of early childhood mental health. Other causes identified included various forms of trauma including domestic violence, child abuse and sexual abuse; drug and alcohol abuse; technology; genetics and brain development. Dawn shared her thoughts on how it can be difficult to pinpoint a specific cause because there is overlap with the following statement:

I think…it's environment. That's where you get your PTSDs, your anxieties, anger…a lot of that. I'm probably a little heavier on environment than I am genetics. I think environment is…drug use, any domestic violence, you know, are their basic nutritional needs met? Do we move a lot? You know, what's your family history of depression? You know we definitely see some of those mental health diagnosis some genetic factors. I don't want to rule that out but I really do think environment is huge. And I guess I don't know where the drug use goes. If you have drug use by a parent when the child is in utero, is that genetics or is that environment or both? Because then it starts to affect your development, but it was also the child's environment.

Grace had a similar response as Dawn stating:

There's all kinds of causes. Nature versus nurture. We have had recent training in

the effect of parental substance abuse or prenatal substance use or alcohol use.

Trauma, I think is huge, whatever that traumatic experience for a child is. We

also find that behavior-wise…a result of parenting so we [our agency] focuses on

the parenting aspect.

All participants agreed that the family plays a role in the health and mental

wellbeing of young children and that while children are resilient, traumatic events have a

lasting impact in a child's life. Faye commented on this perception by stating "I believe

the causes of early childhood mental health concerns tend to be intergenerational trauma,

so experiencing some type of issues with attachment with parents or possibly verbal,

physical or emotional abuse from the parents or caregivers." She also noted that in many

cases the parents had also experienced trauma and it becomes "the cycle where it

continues down to the generations." Cassie agreed with Faye's observation, stating that

child abuse and sexual abuse are tied for the second biggest reason for families seeking

treatment for their children. Cassie expands saying "Those are scars that don't go away,

don't erase. The other stuff on the outside erase but those don't. That is the most

traumatic." Cassie identified domestic violence as the number one cause for early

childhood mental health.

Several participants identify family dynamics and parenting skills as important in

the mental health and development of young children, believing that parents either lack

the skills to teach children how to manage emotions and handle difficult situations or are

not engaging with their children at such an important age. Amy singles out technology as

the cause, remarking:

The growth of technology, just the family dynamics…and how it all impacts brain development. The lack of movement, lack of exercise, the more stationary lifestyle that people live…I think that affects brain development and I'm not convinced that that doesn't affect mental health in some way…The parent in the grocery store with three children…are trying to get her attention. Instead of the parent walking through the grocery store and trying to use that language of what's on the shelf…it's what they're not getting because there's something dividing mom's attention.

Emily, an educator, says, "You kind of know families and you maybe know a little too much. You've had their parents or had their siblings, a lot of family and a lot of disintegration of families is really hard on little ones." While Beth stated that she "has no idea" what causes some mental health diagnosis such as ADHD or autism, she agrees that the family plays a vital part of a child's development and when related to behavior concerns in the classroom, she believes it comes down to the parents. Dawn also says that early intervention can play an important role, noting that society is reactive with mental health. She feels there is "a lot of time lost…we [society] wait a long time and families wait so long and deal with such difficult things for such a long time." Dawn's perception is that early intervention would mitigate some of the challenges families face when dealing with early childhood mental health. Overall, the participants agree there are many causes to early childhood mental health, including genetics, environment, family dynamics and exposure to traumatic experiences.

Reasons for Referral

This theme relates to how professionals determine what warrants a referral to mental health services, as well as the level of services that may be required. Five participants agreed that the severity or intensity of the presenting mental health issue would determine the service needs of a child. Participants articulated similar reasons for referrals, including behaviors or emotional needs that were out of control, specific concerns related to a mental health diagnosis, having experienced a traumatic event, developmental delays, academic delays and generally, students who stand out from their peers.

Grace noted that the screening tool her agency uses combined with reports from the parents and observations made in the home helps determine the level of services needed. Amy shared an example of potential developmental concerns or whether a student lacks particular social skills in relation to the child's peers:

An example may be that the student is within a play group and they don't know how to initiate play within that play group…They have worked on it…in a large group or individually, they've used research based techniques such as role modeling, video modeling…and he or she still doesn't initiate play and according to developmentally typical scale, they're still not doing it, and you know they can't, it's not because of another factor like they are disabled…then I think that is an example of oh, maybe there's something more going on…

Emily describes her experience of understanding a child needs help and providing that assistance to the family:

When you've been in the classroom as often as I have and as long as I have been, it's just kind of …this would be the envelope of norm and when you see all these

things coming out here, you know you're trying to figure out what is the best way to deal with those things that are out of the norm and what type of services might be their best interest because a lot of times parents, they don't know what the norm is.

"Behavior is another one I will refer them for if they're like out of control and can't seem to contain themselves," Beth explains after identifying additional reasons such as speech or academic delays. Beth also recalls her experiences with a particular child who struggled with severe behavior issues and defines that time as "exhausting." Specific behaviors were recognized as warranting a referral. Dawn stated, "Severe…the two I see most are anger and aggression. And then I would say anxiety." Faye also stated, "concerns can be behavioral such as acting out, being violent, emotional ability, having difficulty managing emotions and expressing emotions in a healthy way…anger, sadness, irritability."

Cassie, who works as a mental health provider of all ages, identified attachment as a cause for concern. Cassie expressed the need for healthy attachment between the child and caregiver and that the lack of attachment from either party could be cause for concern. Cassie also receives many referrals for children who have experienced trauma, listing it as the number one reason for referral. She stated trauma as a concern for the following reasons:

If your home life is kind of poopy and then you go to school and you're distracted because you're thinking about and worried about that [trauma], it makes total sense. If you have primary safety needs on your plate, you don't think about reading class.

Faye had a similar response regarding how trauma impacts a child's day stating, "Concerns are normal to a certain level but if they're in some way impacting the child whether it's in preschool or daycare, a referral is important." Dawn agrees with the need for referral saying:

> Some children have experienced severe trauma…such as the death of a parent or sexual abuse or physical abuse or some trauma that's occurred in their life, where you aren't going to get that need met in school or at home. That's a professional mental health concern.

Study participants who are exposed to the classroom setting were in agreement that students who stand out among their peers give cause for referrals. Amy identified it as "any social emotional or behavioral concern or action or whatever it may be that is making that child stand out…not successfully participating…based on my years of experience with children he does stand out." Emily expressed it as "social problems or behaviors that are troubling and they might just be really difficult but they may also be just kind of bizarre that are said and done that are out of the norm" and "sometimes the way they try to get attention…their emotions are over the top and they just seem to be having a difficult time expressing their feelings..." Emily also noted that a change in academics, difficulty remembering or concentrating, extreme behavior changes and acting out of sexuality might also be cause for referral.

Definition of Reliable

Recall that reliability is defined as service provided by competent, well-trained employees with knowledge and experience in working with early childhood mental health services, which are consistent, dependable and effective. This theme provides the

opportunity to compare how similar or dissimilar the study's definition is with that of professionals in the field. When considering which services were most reliable and formulating their own definition of reliability, consistency was listed first by four out of seven participants and dependability (dependability, follow-through and follow-up) was named by five out of seven participants.

Amy defined reliability as "ongoing, consistent, data-driven" stating, "reliable means consistent, implemented with integrity, making sure you're doing what you're saying you're doing, not just follow-through but follow-up." Cassie's definition was similar naming "consistent, trustworthy services that you can count on" as aspects of reliability. Some participants agreed that reliability goes beyond the scope of just being available and dependable in regards to keeping appointments and being there for clients. Dawn expanded on this by stating:

> What I see as an issue is the providers don't follow up with people. They assume they've just stopped coming or don't want to receive the services anymore. My experience with families is that if they're not invested, they're not going to do it…Reliability hinges on that relationship between the provider and the family. If they [an agency] go into a relationship with that person, they're willing to stick it out til the long term so they can depend on them. They follow through and the therapist is there for them.

While she felt consistency was important, Faye asserted that she believed reliability went farther, that it meant addressing all areas of development. She stated, "Approaches for prevention that address social emotional behavioral kind of trauma, brain development, all of the different areas have a lot bigger impact and ability and to be more complete."

Faye believed in order to be reliable 1) a service must be successful "across different circumstances," and 2) "the benefit is seen in various contexts and remains the same." When asked which services she found most reliable, Faye identified a particular resource, Parent Child Interactional Therapy. Faye said, "PCIT because of the involvement of the family. I find that to be more beneficial and reliable because stand alone, individual therapy isn't addressing all the concerns that are happening at home."

One participant from one of the more rural communities initially defined reliability as "easy access, easy scheduling times," as well as "closer proximity." She said her definition would be different if there were mental health services in her community. If location and accessibility were not a barrier to mental health resources, she said consistent care would be most important, as well as making it "almost a no-brainer" for parents to have accessible care. Resources that participants marked as being most reliable were supportive of their clients, communicated well with client, were family focused and had well-trained employees.

Available Resources and Limitations

The following section will examine the theme of "available resources and limitations as it relates to early childhood mental health. This theme identifies types of resources available in the community, what the availability of those resources might be, as well as limitations associated with young children, aged 3 to 5 accessing these resources. A couple of participants had a strong response when asked to discuss available resources for early childhood mental health. Dawn responds:

Well I can tell you they are thin! Sparse! Inconsistent! I think there are times that

we have had a few providers, no more than three that will work with that age

group I feel like. And then I feel like there are times when they move out of the

area or the program closes or the agency decides they're not going to take

children under that age. So I think it's a lot of times that age group that we don't

find a lot of services for. We're thin in all mental health services for adults, you

know, down to children, but I think that age group we have a lot less.

Cassie also stated "There's not a lot. Because a lot of people won't see children under the

age of 8, or I'll hear 5. Under the age of 8 is a common thing." Cassie continued to say

that there was not a lot of education and training on working with children in graduate

school, so personality of the practitioner plays a role. Coming from the perspective of an

educator, Emily discusses a situation she encountered with a student:

I had to get the resources of the people that would take children for counseling so

I presented three options…we had another gal that was in and she's a social

worker and she was substituting…while this gal was on maternity leave and she

was probably a better resource than my guidance counselor…so she had some

names for me. But, that was tough. There weren't a lot out there.

Grace also discussed the struggle in rural communities without preschool saying, "Then

the only other professional that's seeing that child is their doctor for well-child checks. A

general practitioner, they're just not trained in that area as a specialty…for most people to

see a pediatrician, they have to travel." One practitioner had the opposite response;

expressing she thought the community had a lot of resources to offer. She later admits

that while there may be numerous resources, there may also be legitimate barriers to

services for families seeking help.

Several types of resources for early childhood mental health were identified. The Area Education Agency (AEA) was mentioned the most frequently in relation to accessing services for young children. Both Grace and Amy named the AEA as a valuable resource, specifically Early Access services. Grace explained that the AEA would work with a family through Early Access, completing an assessment and determining what services are needed for that child. Amy specified that Early Access is a statewide initiative available to children birth to age 3. Amy said Early Access "involves community services, goal-setting and instruction and education for the family." Families have access to occupational therapy, physical therapy, referrals to mental health counseling and health services such as a general practitioner who can refer to a medical center or a behavior services center.

Each study participant offered a list of available list of resources. These resources included individual and family counseling, play therapy, AEA resources, school-based mental health providers and Eye Movement Desensitization Reprocessing (EMDR). On top of mental health services, participants also named resources such as occupational therapy, Behavioral Health Intervention Services (BHIS), skill-building services, in-home providers, prevention programs and school-initiated programs. Faye identified PCIT as an effective resource, also noting that various Head Starts in the surrounding areas are beginning Teacher Child Interactional Therapy (TCIT). Faye says, "TCIT includes a pretty intense training for teachers, as well as observation and coaching for working with students."

Emily notes that in smaller communities, where the types of resources available are limited, the school takes on the role of providing as many resources as possible.

Emily lists the resources utilized as the guidance counselor, AEA, classroom

modifications and interventions, mentoring and Big Brother/Big Sister. She says, "In the

process of trying to get a family to look at counseling, usually that is because of its

availability, that's one of the last things that we suggest." Both Beth and Emily said they

use different techniques in the classroom they have learned over the years before looking

at outside referrals. Beth indicated this is partly because the AEA expects the teacher to

try alternative interventions in the classroom before determining the next course of

action. During her interview, Beth also shared one resource she found particularly

helpful. A resource guide created and distributed by Families Making Connections, Beth

said every time she has a question as to where she should refer a family to for services

she goes to the guide and is able to look up the needed information. Before having this

resource Beth recalls helping a parent, "I just started calling around trying to find places

to help her that she could look for assistance." She also shared that before having the

resource guide, she did not know where to go or who to talk to for help and struggled

navigating the world of social services.

Emily stated that in working with children and their mental health needs, she is

often sent diagnostic tools, such as Connor Scales, to be filled out by the teacher. Emily

stated that while she is not familiar with many tools available to clinicians, she does not

believe the evaluations she's received are appropriate for young children. Emily stated:

> None of them really are. Because it says, do they take their homework home, are
>
> they able to complete, it's geared for elementary but it's not really for that age.
>
> I've never really gotten one that's geared for that…so there's just a bunch of stuff
>
> that doesn't fit with us so I'm trying to generalize…when it doesn't really fit.

Faye discussed her experience working with children. She notes, "So our clinicians, we have some that do not see children. And those that see children see everyone." She goes on to explain some of the limitations in her agency, saying, "some clinicians choose not to see children because they feel they don't relate as well…not feeling competent working with children." Faye also says that caseloads for therapists who see children are high because there are not many. Faye also discussed the limitations, such as PCIT can create, because it's a more intensive form of therapy that's weekly, with a long time frame and limited number of clinicians able to see clients. Dawn also speaks to the ability to verbalize as a limitation to services provided to young children:

> I know that the people who do the assessment, those who do the LPHAs for those, do not like to do, four is the youngest I've ever had them do for me. They like older, articulate children because it's a hard assessment to do nonverbally, if they don't have verbal skills.

Barriers to Early Childhood Mental Health

This theme examines the different barriers to early childhood mental health that both families and practitioners face. This theme also encompasses future problems that may arise if families are unable to access services or overcome said barriers. Many participants discussed the lack of professionals able to serve young children, which leads to trouble with accessing services due to long waitlists and scheduling conflicts. Practitioners also discussed lack of properly trained individuals, as well as the lack of easy access and affordable training for themselves, allowing them to keep up with the constantly changing needs of diverse populations.

Two participants talked about the need for immediacy when making referrals. With few providers and difficulty scheduling appointments, waitlists become a barrier. Emily describes her experience working with parents:

My experience with everybody that I've recommended counseling to or have needed it, they've never really continued it or followed through because of scheduling. If they could do it in the evening they might have gone but you can't get it scheduled. I know sometimes you call over there and you can't get in for a really long time…If you've got somebody convinced to do counseling and they can't get in for a month, you just, you just, it's never going to happen.

Faye shared a similar response, stating:

They may have early childhood mental health resources available but due to the overwhelming need and not having as much services available to meet that need means that people may be underserved or there may be a waitlist and they're not being served in the correct amount of time…Motivation kind of waxes and wanes so at the time that someone's making the call maybe something really bad has happened and they're really ready at that moment and if they can't get in for two weeks to a month or even longer they feel that maybe things are better. It's easier to minimize what's happening then.

Emily expressed her frustration with early childhood mental health services, comparing it to going to the doctor's office. She says, "You've got a sore throat you take your kid in to the doctor and get an appointment that day, you get seen, you get home and it's all good. It should be that easy."

Dawn discusses her perceptions of the barriers family face when accessing mental health resources listing the number of providers and hours of services first. Dawn points to the rural communities, pointing out that such communities do not have consistent providers and transportation to providers out of town becomes a big obstacle. Dawn shared:

> We have those folks that will do evening appointments one to two days a week; they are much better for our families. Most kids are taken out of school to be taken to therapy, that's what I love about the therapy coming in to the schools. They don't leave the school, removes transportation, all of that.

When asked to discuss barriers to early childhood mental health, Grace has a similar reply stating, "just not enough providers available" and "running into…what age that provider will serve and just availability of providers in the area." She notes that while finding a play therapist can be difficult, it is even more difficult to locate someone who practices in child psychiatry.

Cassie lists transportation as the number one barrier to families accessing services. Several participants reported on parental involvement and challenges, such as seeing fewer parents at conferences and less engagement in activities within the community as a family. Amy also spoke to parental involvement saying, "[they] just don't want anyone else to know what is going on." Amy agrees it may be difficult for parents to invite others into their lives stating:

> Anywhere from a perfectly great family that might just not want anyone in their house based on the fact that they're private people, but the opposite of that is that they're running from the law…there's also that spectrum of people.

Emily shared her belief that parents find accessing services too difficult and too costly, both in terms of time and money. She states:

> I'm asking you to put a lot of money into this and missed work and missed time and probably not something that you can even do. And unless its easy and accessible they're just not going to…I mean it's not that they don't love their kids and its not that they don't want the best and its not that they don't want to do what's best, it's just not within their power to get it done most of the time.

Emily continues on to discuss that professionals are asking some families to take a big step of faith saying, "It's not even out there, nobody even thinks about it as an option for their family…it's not one of those things you do as proactive to take care of your family."

Dawn conveys her experiences with clients in relation to the stigma that surrounds mental health and how it relates to early childhood mental health. She says, "You don't want to be involved with a therapist and if somebody sees me walking into a mental health center or my child meeting with a therapist at schools, they're going to judge me." Dawn and Beth both reported parents being in denial to their child's mental health and were resistant to labels. Dawn stated, "They understood they needed labels to get services but would say 'There's nothing wrong with my child.'" Beth recalled one student she worked with stating, "He was diagnosed…I know he would hate this but he was labeled as behavior disorder because he was so out of control." Dawn remembers one client and the relationship she built with the client stating:

> She was good with me coming to the house because I didn't have a sticker on my car to identify who I was. I was just like a family friend who came and met with

her. But as soon as the agency, the doctor had his marked car and that kind of thing, she didn't like it. So I think it was a label.

Another large barrier identified was the lack of training available to professionals working with early childhood mental health. Participants discussed both needing more training to remain competent in their field, as well as needing more qualified professionals and providing training and education for professionals who work with children struggling with mental health challenges. Cassie explains:

> If you're going to be proficient, you need ongoing training and supervision and so I drive to Des Moines or I fly to Arizona or Chicago, whatever. So there's a lot of expense. And there's nothing here, we're in north Iowa so we have to fly wherever we go, if it's something good.

Cassie also shares that attending trainings comes at an additional cost because the time spent at training takes time away from clients. "If you take a whole day off and you don't see people, or a week, that's a lot of time you're not seeing clients," stated Cassie. Emily views mental health awareness and education as important in the school setting. Emily says:

> Mental health is just not as recognized as other things. You know we get inservices all the time on CPR and about just lots of other things but that's just not something we always get a lot of help with and that'd be another thing. We could all learn from that!

Beth agrees and shares a similar response about the difficulty teachers face when talking to parents about mental health concerns. "I don't think teachers think that they're qualified to do that. Because it is a diagnosis and I think they feel like 'I don't think I'm

qualified to tell her that.'" Beth shares that she feels it's "extremely difficult" to discuss concerns about the mental health of young children with parents. Dawn's perspective was a little different calling on the need for better-trained professionals working with young children. She stated, "This age level of children needs play therapy. I know a lot of people call themselves play therapists and they use play therapy techniques but are not certified."

Finally, participants discussed the implications of whether or not parents are unable to overcome barriers in accessing resources. Cassie reported:

> The lack of any kind of services for kids to help them learn better coping and management in the crazy environment in which they come from is that they're going to carry that with them. And then they create drama and chaos and strife where they go…What we know about trauma is that if it's not addressed, it's still there so if you don't address it, the feelings are just disconnected.

Grace also reported:

> The child's not getting the treatment they need, further down the road they're going to experience more…more difficulties with their own mental health but also I think leading to their school performance, their juvenile justice or adult criminal involvement. I just look at...whatever they were exposed to as a child and if they don't have those services to help their resilience, increases substance use, domestic violence risk…

Amy, who believes there's still a responsibility to find the best care possible, even when some services are not accessible, reported:

You can't do the same thing over and over again…and expect a change. If we know the family …is adversely affecting the student, then we need to do something about it…It's not necessarily that we can control what's happening outside, but we can do something about it [at school].

Finding services. The general idea of this theme is that community professionals working with young children experiencing mental health problems, such as educators, are not always aware of available resources and are unsure of where to turn. Amy spoke to her experiencing working within her agency and the resources they provided but was unable to articulate the types of services available outside of her agency. Amy stated:

I guess if you say early childhood, meaning like birth to 5 or birth, not in to school age, umm, you know, I don't really…I know that there are services out there. Umm, I've been active with the Learning Connection. I don't think that's necessarily focused on mental health.

Beth describes her experience finding resources to offer to parents. When asked if she knew how to get in touch with agencies Beth reported:

I just started calling people that I'd heard of, I called Childcare Resources and they said, well I would try this place and so then I'd call this place and they'd say, well I don't really do that why don't you try this place. And so I started, I just started calling around. And then somebody, I don't know who…gave me this book and so then that helps a lot.

Beth further stated, "There's no streamline process or way to access information." Emily talked at length about the process of locating services for families. She said all the resources she found for early childhood mental health came by "happenstance." Emily

stated, "It was only because of some really weird indirect connections that I was able to give them four difference choices." Emily said it was only because she was talking to the right person or sitting next to the right person she was able to make connections. Emily reported, "All of the connections I try to make for this child are all random information."

Beth expands on the issue of recognizing the needs of a student and locating applicable resources, stating, "Well there's a lot of different mental health things. There's a lot of different aspects of mental health. We have to be very careful with that as educators because we're not doctors and we can't make a diagnosis." Beth noted how frustrating it could be when students exhibited mental health needs, reporting, "This situation wasn't an AEA situation because it was a family in crisis. So I, so I, you know, then I didn't know where to go but I wanted to make sure she got some help." Beth likened her experience to what a family might experience, having no information and no direction in searching for services. Beth stated, "…especially families. They may not know. They may know something is wrong but may not know where to go." "I don't know that they'd be more willing but at least they would be informed. If it got to a point where they decided we needed to do this, they would know where to go and who to call," reported Beth when asked if parents would benefit from more education and knowledge of available services.

Location is Key: Rural Communities and the Schools

This theme demonstrates the impact location can have on a family's ability to access early childhood mental health services and also reveals the role the school plays in rural communities. Most participants named location as a barrier to accessing available

resources due to transportation, time and financial restrictions. Faye expands on this idea saying:

> I think that it may be harder due to other barriers such as transportation and along with transportation, financial possibly, paying for transportation and gas and more time from work and then if the parents are having to miss that…I think they still have the services available but they have to be willing, well willing and able to drive to wherever the services are available.

Emily discusses how location plays a role in accessing resources for early childhood mental health by explaining that in a small, rural community, resources are very limited. Because very few services are located in town Beth says, "Parents would not know where to start or get resources. So that would all fall on the school." Several participants agreed that schools have to be prepared to recognize and implement interventions in the school and classrooms because many times the school is the only resource aside from the doctor the community has available. Emily reported, "The school fills the biggest void possible because that's the only place that people know to look or ask for help." Emily further remarked, "It's a lot" to express the weight this puts on the school. Dawn agreed stating, "Schools, preschools and kindergartens had better be pretty quick to say there are behaviors that are outside of expected…and you need to be able to say to them [parents] in a kind way." Dawn and Emily agreed this is because preschool and kindergarten is the first time many children are observed by someone other than the family.

All participants listed school-based mental health as an available resource in some communities. Most participants agreed that these clinicians could see kindergartners but there were differing views on whether preschoolers could access these services. Faye

reported, "some schools have a contract where a mental health therapist is available for students in the school, which eliminates many barriers." Faye believed preschoolers were likely not seen in the school because "it would not be nearly as effective as in-office therapy." Emily indicated that the secondary schools in her district have school-based therapy but not for elementary students such as preschoolers or kindergartners. When explaining school-based services Emily reported:

> First and foremost, it wasn't really on my radar until this year that we could actually have a counselor come to school and that they could be a counselor, a service not attached to AEA, not attached to use at all, but they could come to the school and service our kids. That's phenomenal! I mean that's truly phenomenal! And because, ah, I can't think of a better, that's almost better than having somebody at the clinic even though they would be serving a lot of other people but it just, it just is, the kids could go in a safe environment. The kids could go and talk in a safe environment. I just think it's the best of all worlds if we can make that happen. And that's definitely on my list of I'm going to, I'm going to keep pushing until that gets done.

Beth spoke to her experience in the classroom and how it helps her to identify students with additional needs. Beth said, "We can't diagnose but to tell you the truth…we know. You see enough. And with my education and experience…because I've taught for a while. A new teacher, it might be different." Beth and Emily explained that many times they make modifications and try different approaches with students because they have had previous experience with successful interventions. When discussing the role of daycare providers and early childhood educators, Faye adds, "I think that often all

that is seen is the behavior problems and they may think oh there's a concern. Maybe it's ADHD or this child's oppositional, which very well may be the case, however I think they're missing something else apart from the behavior that's going on." Faye expressed a need for people in these roles to have access to applicable training to recognize and work with these children.

Caregiver Mental Health and Perception

       This theme addresses the health and mental wellbeing of the parent or caregiver of a child with mental health needs and how that can affect parental involvement. This theme also explores parent perception and the ability to recognize developmentally appropriate or inappropriate behaviors versus identifying mental health concerns.

       Parent/Caregiver mental health. All participants identified the health and mental well being of the parent or caregiver as important. Cassie reported:

> It has everything to do with it. Everything. Parents call and want to bring their kid in and they just want use to fix them and I'll say okay, I'm fine with talking to your kiddo, but I'm also going to want to talk to you and how your attachment is going because attachment is a two-way street.

Amy agreed with the idea of a healthy model makes for a healthy child stating:

> I think it is extremely…it is definitely impactful, whether or not that's biologically, socially and emotionally, within their environment. The kids, if they're modeled how to play, that's what they'll learn. So yes, if the parent doesn't have their mental health under control they're modeling.

Dawn expands on this saying, "I mean of course, that's…a question that…okay well yeah of course it's huge. Does that parent have their own mental health under control? Is it a

value? Maybe they'd see it as a value but they don't know." Dawn goes on say, "you don't know what you don't know" explaining that if parents' own knowledge is limited, it's unlikely to be a concern for their children. When asked about the affect of parental mental health and well-being on the child Beth responded, "an extreme, way, a lot." Beth stated that parents "won't follow through, they ignore, they pretend. They live in their own little land like it's not really happening and then they bring their child to school and want them to fix it."

Emily reported that parental mental health was related to "just about everything" saying:

> One example that just sticks out to me because it was so horrifying. I was doing a
> conference with a mom and she had two little boys. And she brought the little
> boys with her and so she was a little distracted and really having trouble and
> really not hard kids. I mean just normal kids. And she just was absolutely losing it
> right in front of me and…finally the father came and picked up the kids and then
> she just sat and I bet she just sat and talked to me for an hour…And I thought,
> "she is no more capable of going home." And she was in such a mess. And her
> husband was going to have to go to work and you could just see she didn't want
> to go home she didn't want to be with those kids. She was just at wits end because
> of a lot of other stressors…And she's just crying. And I'm sure it was just a bad
> day but you could just tell. She was so stressed, I mean we didn't hardly talk
> about her kid, we just talked and she just unloaded. It was very indicative of what
> that's like at home then.

Grace touched on attachment and reported:

The parents own mental health impacts their ability to handle that child's behavior well before the three to five area, parents mental health impacts their ability to interact with their child. So as an infant that child may not be getting the nurturing and the bonding and interaction that they need and further that down three to five years, as you're experiencing mental health for that child. I think also the parent's mental health impacts their ability to access needed services for their child.

Participants identified parental mental health well being as important to the needs of the child, as well as a key to parental engagement and involvement in mental health services. Cassie reported she struggled getting some parents engaged in therapy with their children, a broad spectrum exists and some parents are more invested than others. Faye agreed reporting, "Family engagement…may limit how effective the intervention might be because the parents are unwilling to be involved. We also have parents that are 'willing' to be involved but not willing to take suggestions or make changes."

Parent perception. Several participants noted parents are not always aware their child is struggling or stands out from their peers developmentally. Emily commented, "They may not be at a desperation point but…they've been dealing with it for a long time and it's still okay and nothing big's happening so it's not that urgency to get help unless it's really inconveniencing your life." When considering the level of awareness a family may possess, Dawn stated:

Some people just don't have that ability to recognize that their family is unsafe or they need therapy or they need outside mental health. They just maybe don't get that. Or they think other parents must deal with these behaviors; they think it's normal. I don't like using the word normal, but they're not unique to them.

Cassie articulates, "No one has a behavior unless there's a need not being met underneath it." Most participants agreed mental health issues are often perceived as strictly behavioral. Dawn says:

> A lot of times parents don't see it as a mental health thing. They see it as 'my kid's naughty' or 'my kid's a brat' or 'my kid doesn't listen to me.' They have more of a negative interpretation of what's going on with their child.

Beth explains that even as an educator it can be difficult to differentiate between development and mental health. She saw it as manifesting so closely to growing up that it was just a part of the normal developmental process. Beth reported:

> Like anxiety or depression, you can't really tell, it's really hard to tell if they're depressed. So I haven't reached out to outside help when they come in and they're anxious because that's kind of part of them growing up and being independent in preschool. It makes kids, some kids very anxious to do that. So I don't, we just try to work through it here.

Dawn gives an example of how parent perception can affect whether a parent considers accessing mental health resources:

> Some parents are in denial that their child would have trauma or mental health…I'm thinking of a mom that I had who her child was diagnosed with PTSD from domestic violence and that mom, I said to her one day, "I get that you weren't scared but do you understand that your child was scared?" And she, she just stopped and she said, "I never thought of it that way because I was never fearful for my life. My child was for me, for my safety, not their own safety but mine!" So sometimes not realizing…

Dawn also identifies that she has parents who exhibit the opposite saying, "I have parents who are like, and 'My kids are crazy!' I would never use those words but they'll use those. 'Something's wrong with my kid!'" Some participants believed parents' perception of challenges their child face come from the lack of verbal skills at such a young age. Beth stated:

It's really hard to define what it is. They don't tell you, they won't tell you what's going on." She went on to say, "In preschool it's really hard to tell…really, really hard because they talk to themselves all the time. They have imaginary friends that they talk to, you know, they play. And I encourage that.

Family Approach in Early Childhood Mental Health

The general idea within the theme portrays the importance of involving the parents and caregivers when addressing the mental health needs of young children. Faye explains how parent involvement is key, especially in programs such as PCIT stating, "it heavily weights the importance of family in therapy and giving family the skills they need." Faye also added that when PCIT was unavailable the child would begin individual therapy with the hopes of including "family-focused" aspects. Faye agreed that she likes to see the family included as much as possible in the therapy process. Dawn identified a need for a family approach to therapy in young children saying, "At that age, it's sort of family because…the parent comes in and does background and what's happened since the last visit, that kind of stuff." Ultimately, Dawn said the decision is left to the therapist to determine whether to take an individual or family approach.

Cassie identifies that in her work the entire family relationship is important. Cassie reported, "I'm always assessing for attachment. Both when they're babies, as they

get older and also parental attachment to the child. That's something I guess I do all the time. I focus on the whole relationship." Beth agrees that early childhood mental health should be approached from a family perspective. "It's so hard to talk to a preschooler. They don't know you and I think it has to be approached as a family. Especially at this age," reported Beth. Grace identified her agency as focusing on the entire family. Grace stated, "So if that parent has needs for mental health, we'll connect them. We have an identified child to serve however we serve the entire family." Grace also noted:

> I think parents also struggle to see their role in helping the child to manage that
> mental health need or that behavior. Sometimes the parents just want the child to
> be fixed. He needs to change. Instead of we all need to change because the
> parents, because if their child has mental health needs the parents need to change
> what they're doing to help those needs. The traditional parenting isn't going to
> work. So we struggle, getting parents to that point.

More Training and More Professionals

This final theme examines what improvements participants consider important to the field of early childhood mental health. The data revealed that most participants felt more professionals practicing early childhood mental health was key. An increase in training, education and awareness in early childhood mental health was also identified. Other improvements included increased collaboration between professionals and working to removing barriers family experience when attempting to access available resources. Faye began by explaining she believes improvements have already been made to the field. She stated:

In the field of mental health there has been more focus on trauma,

attachment…along with that means parents are being more involved with services

or being requested to be involved with services more. Less stigma related to

mental health meaning families are more willing to reach out and there's more

talk about mental health resources that occurs. People are more open to that.

With regard to removing existing barriers, Grace reported:

An awesome improvement would be something that creates more accessibility for

families in rural areas, like where the family doesn't necessarily have to travel to

the provider, the provider travels to the family. Which could really complicate

things. But like in our place, we travel to the family, so it eliminates that barrier.

Even if they could travel, not to the home, but a neutral setting in that community.

Faye agreed stating, "More accessibility to resources meaning that there are more

providers, more bodies. Any way to help with the other barrier that we talked about such

as transportation and services that are available within small communities."

Amy identified a need for "more man power." She elaborated stating, "Without

the man power…you have to prioritize so those who aren't so needy probably don't get

what they need." Dawn had a comparable response asking, "Can we create more licensed

social workers in our area?" She went on to say, "The rural areas always have the

disadvantage. The professionals that live in the rural areas are the ones that grew up in

the rural areas and appreciate that lifestyle. So I think it's more professionals." Emily

said:

I think it would make a huge difference if we could get a mental health person

that could work with little ones in our school. If we could make that happen then

there would be a lot of people what would actually use that.

Training in early childhood mental health was a need recognized by Cassie.

Cassie reported:

More education that could help with things that we send stuff out for, we don't do

enough ourselves. Knowing what to do specifically and how to manage those kids

would be helpful for not only the therapist but for school personnel and for

everyone.

Faye also discussed how training in the school could be the road for important change.

Faye believes school staff could benefit from being more aware of mental health issues

such as trauma and attachment and how to "better meet those kids' needs" stating that

such training can have a "profound impact" on the success of those students. Cassie

indicated training was needed to "allow people to separate out the people from the

behavior." Faye also disclosed that she feels there is a need for "more complete

programming" to address all areas of mental health.

Dawn named an increase in awareness and acceptance as improvements that

could help reduce stigma related to mental health and making families more comfortable

accessing resources. Emily would like to see more collaboration between colleagues and

peers. Beth felt she could not speak to what improvements need to be made to early

childhood mental health because she did not have enough knowledge on current available

resources. The participant agreed awareness and education was important.

The seven participants interviewed for this study shared their diverse and complicated experiences with early childhood mental health services for children aged 3 to 5. The participants' responses permitted the researcher to define ten major themes within the data. The ten themes reviewed in this study include: (a) Believed Causes of Early Childhood Mental Health, (b) Reasons for Referral, (c) Definition of Reliable, (d) Available Resources and Limitations, (e) Barriers to Early Childhood Mental Health, (f) Location is Key: Rural Communities and the School, (g) Caregiver Mental Health and Perception, (h) Family Approach in Early Childhood Mental Health and (i) More Training, More Professionals. In the following section, the researcher will analyze how the findings relate to prior research, the strengths and limitations of the study and will discuss implications to social work practice, policy and research.

Discussion

The purpose of this study was to determine whether early childhood mental health services are accessible and reliable in rural northeast Iowa. The research question addressed was: Are early childhood mental health services accessible and reliable? Qualitative interviews were conducted with seven professionals who work with children aged three to five that have mental health needs. The findings of this study will be discussed with regard to how the findings compare and differ from the current literature.

Comparisons to the Research

The family. The purpose of this section is to compare the findings of this research study to the findings of previous research studies found in the existing literature by noting parallels and differences between the two. One prevalent theme among both the past research and this current study is that the mental health and wellbeing of the

caregiver has influence over the child. Cousins discusses that the wellbeing of a young child is based on the relationship that child has formed with the parent or caregiver (2013). When parental health, whether physical or emotional, is poor there is a greater chance for poor attachment between the parent and child. The parent cannot respond to a child's needs in the way the child requires. Grace had noted that parents' mental health impacts their ability to handle the behaviors of their child, as well as their ability to interact with their child. This study suggests that parental wellbeing can contribute to neglect or the inability to recognize a child's mental health needs. Cousins' research would agree defining neglect as the failure to meet a child's psychological needs, including unresponsiveness to the child's basic emotional needs (2013). This study focuses on how the health and well being of the parent may affect the child but it should also be noted that the reverse might be possible. When a child struggles with mental health issues, this may become a trigger for the caregiver, creating mental health issues for the adult. Regardless of which came first, it can be said the parent-child relationship is central to healthy development (Dickstein, 2015; Larrieu & Dickson, 2009).

Parent perception ties into this theme and was prevalent in the data. Parents may not always be able to recognize when their child is struggling due to mental health challenges. Parents view their child's behavior as normal "kid" behavior, saying things such as "boys will be boys." Behaviors of very young children can be difficult to separate between problematic behaviors and those that are developmentally appropriate (Elias, 1998). One participant noted that she has parents who identify their children as "crazy" or believe something is wrong with their child. These findings indicate that parents may have a basic understanding that child needs help but does not understand

what is causing it. The parents may perceive their child as unruly or out of control instead of recognizing a true mental health need.

The findings of this study also indicated that a family approach is important to therapy and addressing the mental health needs of the child. Children aged three to five do not always have the same ability to communicate as older children, leaving clinicians to rely on the parents or caregivers to answer questions and tell that child's story. Even with effective programming, family engagement and cooperation is key (Oh, 2014; Axford, 2009). Parents have to know what services exist and believe those services are worth their time. This idea is supported by Oh who says parents' perception of mental health challenges is vital to accessing and using services (2014).

One participant recognized the need to provide parents with an understanding of how to help their children, speaking to how traditional parenting techniques are not always appropriate for children with mental health needs. Parents may require additional resources or guidance in these situations. Professionals in the field are seeing a strong correlation between parent wellbeing and the mental health and wellbeing of the child. Clinicians are also noting the importance of family involvement and engagement in therapy. The discovery of this information in the current study supports prior research that relationship-based strategies and mental health promotion in communities are necessary (Tomlin & Viehweg, 2003). This finding suggests that resources must address the needs of both parents and children.

Reasons for referral. Many similarities were found between findings of studies in the review of the literature and the findings in this study with regard to why a child may be referred for mental health services. The findings in this study correlate with

previous research that referrals are made when a child's behavior are outside the expected "norm" of behavior. Approximately 10-20 percent of preschool age children show negative behaviors that are not in the realm of "normal" development (Elias, 1998). This study found that children who stood out from their peers in social and emotional development were likely to be referred. Both the findings of this research and that of previous literature indicate that mental health needs are witnessed at home and in the classrooms. Giannakopoulos et al. (2014) stated that nearly one in seven children will experience a mental health disorder. Past research speaks to problems in preschool predicting anxiety disorders, depression and aggression or delinquency later in life (Oh, 2014). One participant's response supports this theory saying that the behaviors in her classroom are indicative of later years and that teachers frequently come to her to inquire on past behavior when experiencing difficulty in their classrooms.

Barriers. A comparison of previous findings in studies and this current study show some differences in perceived barriers families may encounter. Findings of previous studies in the review of the literature focuses on barriers such as lack of information about available services, knowing when to seek care, and a distrust of the system (Bringewatt & Gershoff, 2010). Similarities exist between the types of barriers observed by mental health professionals versus other community professionals and families. The findings of this study indicate that professionals working in the mental health field identify barriers as lengthy waiting lists, gaps in care, funding restrictions, insurance limitations and lack of resources and training. The findings of this study show that while educators would agree with these barriers, there are other barriers they find to be more pressing such as knowing how and when to access services. Current findings

state that transportation and cost play a big role in whether a family can access services. Because many families in rural northeast Iowa have to travel to neighboring communities to access resources, they are far less likely to engage in or continue participating in services.

Training. Training or lack thereof is a theme woven within prior studies in the review of the literature and current findings. The current study demonstrates a need for not only additional training in the area of early childhood mental health, but also a need for additional clinicians in practice. While clinicians may use play therapy techniques, there is no requirement to work with young children (Tomlin & Viehweg, 2003). This is one area where this research study and previous studies deviates from one another. Tomlin & Viehweg (2003) indicate that there is no specific national licensure or certification to document expertise in the field of early childhood mental health. The findings of this study indicate that mental health practitioners can become registered play therapists to indicate their expertise in working with young children. One participant recalled that she had no specific training for working with children while completing her Master's of Social Work program. She felt this directly impacts the confidence practitioners feel when taking on young children as clients.

In the review of the literature, one study highlights the importance of training those other than mental health professionals. Edlefsen & Baird (1994) pose that teachers are vital because they are typically the first person to identify the need for special services and as such must believe in and understand the mental health system. The findings of this study coincide with this idea that other professionals untrained are less likely to make appropriate referrals to mental health services and even a little education

can go a long way (Virmani et al., 2013; Giannakopoulos et al., 2014). Making the right referral is difficult, especially without education and training.

Types of services. The types of services available are inconsistent and dependent on many variables. The findings of the current study show that location plays a key role in the kinds of services families have easy and reliable access to. Findings from one study suggest that 70-80 percent of children that receive services do so in school settings (Bringewatt & Gershoff, 2010). The current study shows this may only be true in some communities as rural communities receive minimal or no mental health services, and those services that are readily available are often sporadic and unreliable. Prior research also indicates that many preschools have a process already in place for making referrals based on problem behaviors experienced in the classroom. The current study did not always support this finding. Some professionals in the study could identify a referral process for three to five year olds, but several professionals indicated they were at a loss for how to make mental health referrals for families. This study and past research indicates available services if you have the resources to access them such as mentoring, transportation, in-home treatment and individual, group and family therapy (Bringewatt & Gershoff, 2010; McWilliam, Harville, & Young, 1996; Cousins, 2013; Giannakopoulos et al., 2014; Stone, 2012).

Further Impressions

The researcher had several thoughts and ideas throughout this study. First, the researcher wanted to interview a diverse population of participants, hoping to get a broad spectrum of perceptions. The researcher expected that the responses of each participant would be different based on the role they fulfilled for a child. The expectation was that

mental health professionals and social workers would have experiences greatly different from that of educators. The current findings support this hypothesis. As expected, educators had far less knowledge of mental health services, how to access those services and how to provide help for students. Even though many times these participants could identify that a child stood out from their peers, the participants struggled to identify and articulate what was available in their communities. In contrast, the social workers and mental health professionals could easily identify services and how to make referrals and what warrants a referral to such services. The researcher expects that the struggles teachers encounter in locating and making referrals to mental health services are similar to what parents may experience.

The researcher defined reliability for the purposes of this study but found similarities in the responses of participants. Nearly all participants identified consistency as an important piece of reliability. The researcher noted that many participants felt that dependability was also important, although it was described in various ways including requiring follow-through or follow-up, checking in on clients and being present with clients.

The researcher also would note that some statements made by participants were especially direct in regards to the causes of early childhood mental health. These responses are a significant find because they are the true perceptions of these professionals and this phenomenon is very real in communities and needs to be addressed. The researcher felt these responses were open and honest, providing valuable insight in gaps of understanding and education regarding mental health. This insight

provides a valuable opportunity to develop training and education in communities aimed at awareness.

Strengths and Limitations of the Study

This study sought to understand and explore the available resource options for young children experiencing mental health challenges and their families. This study used the subjective experiences of community professionals that work with young children and have experience with early childhood mental health issues and needs. Because research on early childhood mental health services is a more recent focus in the mental health arena, available studies in the review of the literature are limited. Infant mental health has been studied more extensively and provides a very important contribution, which will likely lead the way to more research being conducted on early childhood mental health. The field of social work benefits from this study as it provides additional literature and research into accessibility and reliability of early childhood mental health services, identifying common gaps and barriers and increasing knowledge of appropriate resources for families and their children, as well as practitioners working with this population. This research is important to the field of social work as it relates to working with children, at an early age where potential interventions could have a dramatic impact on their future mental health, addressing these needs at a young age instead of as an adult. The participants in this qualitative study provided a real voice to those who work in this field. The researcher of this study has had personal experience navigating the world of mental health services for young children, allowing an understanding of the challenges children and parents face when trying to identify and connect with possible resources.

Several strengths were found in this study. The first strength is the exploratory nature of this study. While there is research directed at early childhood mental health, most research is not directed towards children aged three to five, but instead focuses on infant mental health. By expanding the research to this specific age range, providers of early childhood mental health services can begin to identify the needs and gaps within such services through the collection of data. Existing literature is mostly aimed at the causes of early childhood mental health and the ability to recognize the need for services, while this study focuses on the ability of early childhood professionals to access reliable mental health resources for young children. A final strength of this study would be the methodology used in completing this study and the ability to replicate the methodology in other parts of rural Iowa. Additional qualitative data could be derived from those studies to determine the needs in those areas. Such data could provide a platform of change for rural Iowa, across the state, not just in the northeast region.

Limitations of the study could stem from the researcher's personal interest and experience with early childhood mental health services. This may have created the possibility of researcher bias. To limit researcher bias, the researcher reviewed interview questions, codes and themes identified with the research chair and with a colleague. Lack of knowledge and understanding surrounding early childhood mental health may have been an additional limitation. With only a few months to complete interviews, transcribe, and code the data, lack of time was a limitation.

Sample size was an additional limitation to the study. The researcher attempted to recruit at least eight professionals working with young children experiencing mental health challenges. This researcher interviewed seven participants, giving a somewhat

narrow, subjective lens through which available resources were discussed. The researcher struggled in recruiting participants. The researcher contacted professionals in the surrounding school districts, mental health agencies and community agencies dealing with early childhood mental health concerns within sixty miles of the researcher's location. The researcher sent emails and left voicemails for 84 individuals, receiving feedback from only 17 individuals. Only seven of the ten professionals who responded participated in the study. Finally, given the nature of the study, professionals may not have felt qualified or able to speak to early childhood mental health services. Because the sample size is small, the researcher hesitates to generalize these findings to mental health professionals, social workers and educators as a whole.

Implications for Social Work Practice

The findings of this study offer several implications for social work practice and potential changes that could be made in early childhood mental health. The findings of this study indicate an overall lack of mental health professionals who are trained and confident in working with young children. Those professionals who are available have long wait lists and limited availability. An important area of discussion is that more education and training should be made available to mental health professionals. Putting emphasis on the importance of early childhood mental health and providing more resources for training would help create competence and confidence among professionals who work with young children. Opportunities in school as well as continuing education in the field is vital to producing clinicians who feel able to work with this clientele.

Another possibility for social work practice is to develop ways to reduce some of the barriers families face when accessing resources. As one participant noted, their

services are more readily available to clients because the workers go into the homes instead of the families coming to them. The participant noted that most of their referrals come from the families themselves because families know those services are available to them regardless of challenges they may face.   Families experience success within the program and suggest the program to their friends and family. While mental health clinicians do not provide these services, it would be worth looking into programs such as this to observe ways in which the service providers help clients overcome obstacles. Reducing barriers such as transportation could also help reduce costs, such as time off from work or children missing school, or even the financial cost.   Bringing mental health services into the schools is another way many communities are reducing barriers. Families may be more willing to engage or consider referral to mental health services if they do not have to worry about the other obstacles.

Implications for Policy

The implications for social policy in this study occur at the macro level. Policy changes need to be implemented in regard to training and education on early childhood mental health. In-home providers, educators, occupational therapists, BHIS workers, social service providers, doctors and other medical professionals should receive continuing education to ensure they have knowledge to recognize mental health needs in young children, as well as understand how to identify resources and make appropriate referrals. Mental health professionals working with young children should receive additional training specific to early childhood counseling, such as play therapy to help boost confidence and competence in this field of expertise. Graduate programs should

also consider providing more opportunities for students to concentrate their classes in early childhood mental health and working with children.

This study identifies various barriers such as transportation, awareness of when and how to access services and finding resources in rural communities. An important policy consideration is identifying ways to improve access to available resources. Addressing these barriers will ensure children have consistent ongoing care, which will increase mental health outcomes and reduce costs to society in the future.

Implications for Future Research

More qualitative and quantitative research is necessary in the field of early childhood mental health. Specific research on early childhood mental health, especially which focuses on three to five year olds is needed. Researchers would benefit from looking at the research completed for infant mental health and duplicating that research a couple years later in development. Because early childhood mental health has been identified as vastly important to the later emotional and social development of children, it is essential that social workers and researchers be proactive and informed. This study reveals that while mental health services may be reliable, in a rural community, this will not matter if such services are not accessible. Further research would benefit from considering what factors make a service more accessible and ways in which accessibility can be accomplished.

In conclusion, the findings of this study are similar to the findings of previous studies; nevertheless, continued research of early childhood mental health services is imperative to addressing the needs of young children. This study offered the experiences of professionals working with young children aged three to five who had mental health

needs. Although the sample size was small, the participants' insights about community

resources were revealing and diverse. Accessible, reliable mental health care is crucial to

the developing minds and bodies of young children and can have a far-reaching effect. If

professionals and families have a greater awareness of how to access resources and to

identify which resources best address the needs of the child, these resources are much

more likely to be utilized to their full extent.

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Appendix A

Phone/Email Script to Key Agencies

Hi, my name is Rae Lynne Chase and I am a graduate student in the School of Social Work at St. Catherine University and the University of St. Thomas. This study is being conducted under the supervision of Dr. Catherine Marrs Fuchsel, PhD., LICSW, LCSW (email: clmarrsfuchsel@stkate.edu; phone number: (651) 690-6146). I am conducting a qualitative research project on accessibility and reliability of early childhood mental health services. The research project will seek to answer the question: Are early childhood mental health services accessible and reliable? The purpose of the current study is to examine mental health services available to young children and their families to determine if those services can be considered reliable. This includes observations and experiences of preschool teachers, mental health counselors, AEA 267 personnel, and teen parent educators in many different settings. The current study will consider obstacles and barriers families encounter when looking for mental health services for their young children, as well as consider whether the available services are reliable, in the hopes that it will elicit conversations on how to fulfill a growing need.

Professionals working with young children experiencing mental health challenges include preschool and kindergarten teachers, mental health counselors, AEA 267 personnel, teen parent educators, Department of Human Services case workers, and daycare providers.

I am conducting in person interviews that will take approximately 60-75 minutes. If you are interested in participating in this study, please call me at (xxx) xxx-xxxx or you can email me at chas001@stthomas.edu. Your participation in this study is greatly appreciated and I look forward to meeting with you. If you have other questions or concerns regarding this study and would like to talk to someone other than the researcher, you may also contact John Schmitt, Institutional Review Board Chair of the St. Catherine University Institutional Review Board, at 651-690-7739 or by email at jsschmitt@stkate.edu.

Sincerely,

Rae Lynne Chase, BSW

Appendix B

Research Information and Consent Form

Accessibility and Reliability of Available Services in Early Childhood Mental Health

St. Catherine's University

Introduction:
You are invited to participate in a research study investigating the availability and reliability of early childhood mental health services among children aged 3 to 5. This study is being conducted by Rae Lynne Chase, graduate student in the School of Social Work Program at St. Catherine University and the University of St. Thomas, under the supervision of Dr. Catherine Marrs Fuchsel. You were selected as a possible participant in the research because you are a professional working with young children who may experience mental health challenges. Please read this form and ask questions before you decide whether to participate in the study.

Background Information:
The purpose of this study is to determine the accessibility and reliability of services available for early childhood mental health, among children aged 3 to 5. Approximately 8-10 people are expected to participate in this research.

Procedures:
If you decide to participate, you will be asked to answer approximately 10-12 questions related to your experiences working with young children with mental health needs in a 45-60 minute interview, agree to an audio-taping of the interview that will be used for this research, agree to allow the information to be presented to the public in a non-identifying way, and agree to allow a colleague to review the data and transcript of the interview for a reliability check. The colleague that will review the data and transcript for reliability check will sign a confidentiality agreement related to the interview transcriptions he or she is coding. A reliability check will be completed to ensure I did not miss any important information while reviewing the data and transcript. Interviews will take place at a time and place we agree upon. This consent form will be signed and any questions you may have will be answered at the time of the interview, before the interview begins. The information gathered from this interview will be presented to members of the public who choose to attend the presentation on May 16, 2016. The interview will take place in a private place of your choice or via telephone on speakerphone with no one else present but the researcher.

Risks and Benefits of Being in the Study:
The study has minimal risk. There may be some discomfort in talking about some examples of families you have worked with in the past, where the families were unable to locate or utilize resources for their child. This interview may cause some stress on your schedule or inconvenience in transportation and time.

There are no direct benefits to you for participating in this research.

Confidentiality:

Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented.

I will keep the research results on a password-protected computer and in a locked file cabinet in my home. Only myself, my research advisor, Dr. Catherine Marrs Fuchsel, and 1-2 other classmates will have access to the records while I work on this project. I will finish analyzing the data by April 2016. I will then destroy all original reports and identifying information that may be linked back to you by May 31, 2016.

Voluntary Nature of the Study:
Participation in this research is voluntary. You are also free to pass on some of the interview questions. If you choose to withdraw from this study at any time, your relationship with the University of St. Thomas and St. Catherine University will not be affected.

Contacts and Questions
If you have any questions, please feel free to contact me, Rae Lynne Chase, at xxxx@stthomas.edu or (xxx) xxx-xxxx. You may ask questions now, or if you have any additional questions later, the faculty advisor, Dr. Catherine Marrs Fuchsel, can be reached at 651-690-6146. She will be happy to answer any questions you may have. If you have other questions or concerns regarding this study and would like to talk to someone other than the researcher, you may also contact John Schmitt, Institutional Review Board Chair of the St. Catherine University Institutional Review Board, at 651-690-7739 or by email at jsschmitt@stkate.edu.

You may keep a copy of this form for your records.

Statement of Consent:
You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing in this form, please know that you may withdraw from the study at any time so no further data will be collected.

I consent to participate in the study and I agree to agree to an audiotaping of my interview.

_____

Signature **Date**

_____

Signature of Researcher **Date**

Appendix C

Main research question: Are early childhood mental health services accessible and reliable?

Questions for qualitative interview:

1. Tell me about your educational background and work experience.
2. Tell me about available resources for early childhood mental health.
3. Which resources do you feel are the most reliable?
   a. What do you consider reliable?
4. Describe your experiences with early childhood mental health services in your community.
5. What would you consider determining factors in deciding the level of services required? Tell me more about that.
6. What warrants a referral for mental health services in young children (age 3 to 5)?
7. What have you observed the causes of early childhood mental health to be? In your opinion, what effect does the health and mental well being of the parent/caregiver have on early childhood mental health?
8. What are the implications of lack of accessible or reliable early childhood mental health services?
   a. What are some of the barriers you have observed to accessing resources?
9. Where do you see improvement for early childhood mental health?
   a. Improving existing services or creating new interventions?
10. What are the diagnostic tools used in early childhood mental health?
11. Have you observed resources for early childhood mental health provided by the school district and could you describe those services?

Appendix D

Coder Confidentiality Agreement

I am conducting a study about the accessibility and reliability of early childhood mental health services and resources.

This study is being conducted by Rae Lynne Chase under the advisement of Faculty Advisor, Dr. Catherine Marrs Fuchsel, Ph.D., LICSW, LCSW, a faculty member of St. Catherine's University and University of St. Thomas School of Social Work.

Confidentiality:

Confidential information includes all data, materials, products, technology, audiotapes, computer programs and electronic versions of files saved to portable storage devices. All information you obtain related to this study will remain confidential. No one else may have access to the records.

Contacts and Questions

My name is Rae Lynne Chase. If you have questions, you may contact me at (xxx) xxx-xxxx or my research chair, Dr. Catherine Marrs Fuchsel, telephone number 651-690-6146. You may also contact the St. Catherine's University Institutional Review Board at 651-690-7739 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Agreement of Confidentiality:

I, _____, have read the above information and agree to confidentiality as stipulated above. I further agree not to disclose, publish or otherwise reveal any of the confidential information received from the researcher or interview participants.

_____   _____
Signature of Coder   **Date**

_____   _____
Signature of Researcher   **Date**