Central California Children's Institute

California State University, Fresno

STRENGTHENING REGIONAL CAPACITY IN INFANT-FAMILY AND EARLY CHILDHOOD MENTAL HEALTH:

Recommendations for Enhancing Promotion, Relationship-Based Preventive Intervention and Treatment

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I. Project Background

In November, 2009, First 5 Fresno County, along with several other funding partners (First 5 Merced County, First 5 Tulare County, and the Fresno County Department of Behavioral Health), entered into an agreement with the Central California Children's Institute to explore ways to strengthen the tri-county region's (Fresno, Merced and Tulare) capacity to promote healthy social and emotional outcomes for young children, and the provision of quality training in infant-family and early childhood mental health (IFECMH) for those who work with them.

In the past, Fresno County was involved in state-level efforts to enhance the skills of infant mental health practitioners. Specifically, Fresno participated in the State-supported California Infant Mental Health Group dating back to 1994, WestEd's Infant Mental Health Development Project in 1998-1999, and a number of other related State First 5, WestEd, and federal Maternal and Child Bureau-funded projects between 2000 and 2009 (Richardson, 2009). Fresno was also represented on the California Infant-Family and Early Childhood Mental Health Training Guidelines Workgroup responsible for developing the Revised Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health (2007 – 2009). Thus, practitioners in Fresno County have long recognized the importance of this work, and there have been many local champions in its implementation.

During this fertile period of state-level activity in infant mental health*, a number of professionals in Fresno were also participating in learning labs: a small group, multidisciplinary training model that proved to be effective in helping professionals hone their skills in relationship-based work, which is the core of infant mental health. Also, the Fresno County Department of Behavioral Health provided training dollars to support the matriculation of several of their staff in the Alliant International University's certificate program in Infant-Preschooler Mental Health. An ongoing concern, however, was that, while the need for preventive intervention and treatment for infants and their parents was steadily growing in the tri-county region, resources were drastically dwindling, and far too little was being done to promote healthy infant-family relationships before problems occur. Also, local activity waned a bit after the state-level projects were completed. The current local project was launched to explore ways to reengage the region in collaborative infant mental health efforts, to increase the emphasis on upstream infant mental health promotion strategies, and to assure high quality, culturally competent services for those infants and families requiring preventive intervention and treatment.

The histories and current practices in training infant mental health practitioners vary greatly in Fresno, Merced and Tulare counties. Merced County reportedly has limited structure and engagement at this time, while Tulare County is fairly cohesive, though still lacking somewhat, in training resources. Giving the varied stages of development and engagement in IFECMH training, these three counties are very well-positioned to learn from and support each other in the interest of a regional approach. The Regional IFECMH Steering Committee and other activities conducted during this project encouraged information-sharing and collaborative thinking across the three counties.

*Throughout this document, the terms "infant-family early childhood mental health" and "infant mental health" are used interchangeably.

Although there are several academic training programs in infant mental health in California, a growing trend is to develop community-based training programs that are accessible to those already in the field (for example, the Santa Clara County Infant-Family Early Childhood Mental Health Certificate Program). These community-based models of training differ in length, cost, cohort size, etc. Because the field of infant mental health is multidisciplinary by definition, these programs enroll professionals from a number of different disciplines, including early care and education, psychology, social work, occupational therapy, nursing, public health, and speech and language pathology, among others.

A major catalyst for the development of new training programs in recent years has been the adoption of the Revised Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health by the California Infant-Family and Early Childhood Mental Health Training Guidelines Workgroup in 2009. The Guidelines outline specific knowledge, skills and competencies that must be achieved in order to receive endorsement in infant mental health as a core provider, an infant mental health specialist, and reflective practice facilitator (see attachments). The California Center for Infant-Family Early Childhood Mental Health housed at WestEd's Center for Prevention and Early Intervention (CPEI) is the endorsing agency.

In thinking about ways to build the region's capacity in infant mental health, the objectives of the current project were to:

1) Assess the region's readiness and interest in expanding training opportunities
2) Scan the environment to identify potential partners and key players
3) Create opportunities for dialogue about how IFMH training should be structured
4) Examine strategies for increasing cultural diversity and competency in the workforce
5) Propose a model for regional delivery of infant mental health training.

After more than a year of convening, dialogue and strategy development, broad consensus has been reached regarding a training approach, the host organization, and how to link together key community efforts that can augment promotion and preventive intervention. This report provides an overview of what we have accomplished and proposes several recommendations for consideration.

II. What is Infant Mental Health and why is it important?

The Zero to Three Infant Mental Health Task Force (2002) defines infant mental health as the developing ability to "experience, regulate, and express emotions; form close interpersonal relationships; and explore the environment and learn all in the context of family, community, and cultural expectations for young children" during the first three years of life. Infant mental health also includes family functioning and parental-child "goodness of fit," as well as the health and development of the brain.

Until the last decade or so, the mental health of infants was largely ignored, even in clinical settings where their parents might have been obtaining mental health services. Though there is evidence that the mental health challenges of parents affect the development of their children (Goodman and Brand 2009), the focus of treatment is most frequently on symptoms experienced by the adults, and not the effects on parenting on the child (Hinshaw-Fuselier, Zeanah, and Larrieu 2009). Hinshaw et al. point out

that many clinical training programs in mental health neglect to focus on how infants and toddlers develop and can be treated. Yet, increasingly, practitioners who work with children but are not trained in mental health (such as child care workers, primary care physicians, and nurses) are "expected to work within the relationship context to promote 'infant mental health,' regardless of their preparation to do so" (Hinshaw et al.).

There is little consensus regarding the best ways to train practitioners to address infant mental health (Hinshaw-Fuselier et al. 2009:533). Many states have implemented certification or endorsement programs. These programs vary greatly in their degree of intensity, length, and breadth of knowledge. One clear trend is that training programs are cross-disciplinary, enabling professionals from a wide variety of specialties to gain knowledge and skills that are appropriate for their settings. Another trend is towards having multiple levels of endorsement or certification. Thus, depending on the level of family involvement and the focus on promotion versus prevention, and even intervention and treatment, practitioners can gain appropriate levels of training.

As Zeanah and Zeanah (2009) point out, many people still find it difficult to combine the terms "infant" and "mental health" in the same sentence. "Is it reasonable to think of infants as having mental health problems? Or does it make more sense to think about them as being at risk for problems later"? People do not like to associate the innocence and promise of infancy with the stigma and struggle of mental illness. In reality, the work on infant mental health only partially involves confronting mental disorders. There are at least three levels of involvement of infant mental health practitioners in families' lives: promotion, preventive intervention, and treatment.

The Center on the Social and Emotional Foundations for Early Learning (CSEFEL) stresses the importance of early care practitioners as an important resource during normal development, helping to address such issues as stranger anxiety, toilet training, emotion management, and becoming autonomous. Whether in a home or other setting such as childcare, practitioners can support the relationship between parent and child, explain typical development and individual temperament, teach positive behaviors, and help reduce family stress, thereby *promoting* the mental health of all the family members involved . Practitioners can also help *prevent* potential mental health issues that may arise by noticing risk factors in the family or the child. Practitioners may be able to provide instrumental support by helping the family connect with agencies that can reduce the effect of risk factors facing the child. Subsequently, infant mental health practitioners may *intervene* on a child's behalf if they are aware the situation at home is abusive, neglectful, or otherwise harmful. Once a child has been exposed to a harmful or risky environment, infant mental health specialists become key players for *treating* infants in the hopes that early intervention and treatment will lessen the impact of hurtful environments or relationships.

In fact, despite our societal tendency to ignore the importance of infant mental health, it lays the groundwork for future relationships, mental health, and even physical health. It is well established that brain circuitry is developing at a very rapid rate during the earliest months and years of life, creating the very architecture and processes that will later become difficult to change (Zeanah and Zeanah 2009). Previous studies have established a clear link between risk factors experienced in infancy and risky

health behaviors as adults, along with "depression, alcoholism, substance abuse, heart disease, cancer, chronic pulmonary disease, obesity, and diabetes, among others" (Dube et al 2003 and Feletti et al 1998 as cited by Zeanah and Zeanah 2009). There are several sensitive or critical time periods during the early years of development. Zeanah and Zeanah describe a study conducted by Nelson et al. (2007 as cited in 2009) in which children who were removed from orphanages and placed with foster families prior to 24 months of age experienced substantial increases in IQ, while those placed after 24 months did not experience nearly as many gains.

Further, many researchers have established that early relationships serve as internal working models for future relationships. The quality of attachment with the primary caregiver has a cascading effect, first on early friendships, then on peer relationships during adolescence, and finally on the quality of attachment and the experience of negative and positive emotions and coping behaviors in adulthood (Simpson et al. 2007). While our attachment style is not set in stone by the time we are two years old, a person's attachment style as an infant has been shown to be associated with his/her attachment style later in life. Children with secure attachments learn that they can depend on the objects of their attachment to provide comfort and security, especially in times of stress. Children with insecure attachments develop coping styles that are either hypervigilant or dismissive in the face of stress because they do not feel the target of their attachment can provide a "secure base." Mikulincer and Shaver (2003 as cited by Simpson et al. 2007) distinguish the two groups by saying that secure individuals are able to use more problem-focused approaches to coping while insecure individuals use more self-focused coping strategies.

Clearly, infant mental health practitioners can encourage positive developmental trajectories. In addition to recognizing risk and protective factors and potential psychopathology, infant mental health practitioners may be able to make it less likely that the aggressive two- year old becomes an aggressive nine- year old. Zeanah and Zeanah (2009) cite both Dishion et al. (2008) and Knudsen et al. (2006) who argue that the benefits of intervention/treatment are stronger when they occur earlier. Dishion et al. suggest there are several reasons why this may be the case. First, early intervention may prevent less serious externalizing behaviors in young children from becoming more serious versions of externalizing behaviors. Second, parents may be more capable of change while their children are young, and may experience fewer stressful experiences as the result of intervention. Further, when children are very young, the optimism experienced by parents is higher than as the children age.

Thus, the practice of infant mental health has many incredibly important implications. Infant mental health practitioners are in a unique position to potentially promote positive mental health and behaviors among infants and caregivers, help prevent negative behaviors on the part of the caregiver as well as the infant, intervene when children are at risk due to parental mental illness, stress, financial strain, legal issues, etc., and finally treat children who have already been negatively affected by their environment or relationships. In the final case, practitioners can provide both a supportive caregiving model and be a resource for connecting the family to people and institutions that may be able to help.

III. Conceptualizing the Work of Infant Mental Health: Promotion, Relationship-Based Preventive Intervention, and Treatment

In 2000, a conceptual framework for defining and operationalizing the work of infant mental health was adapted by Heffron (2000) based on Caplan's three concepts from the field of preventive psychiatry: promotion, preventive intervention and treatment. Heffron's framework clarifies the various types of programs that are being implemented in multiple settings and addressing various audiences. She proposes using the terms promotion, *relationship-based* preventive intervention and treatment to frame the work. These terms are similarly proposed for describing the various levels of work that need to happen in our region if we are to strengthen our capacity in infant mental health.

Promotion

Infant mental health promotion, also referred to as wellness promotion, is very broad in its reach in that it is aimed at the general population to encourage actions, behaviors and policies that promote wellness. This work varies widely by audience, sector and discipline. It ranges from providing parenting education classes, to disseminating brochures in pediatrician's offices about how the brain develops and the importance of early relationships, to promoting policies such as the Family Medical Leave Act that allow parents to have more time at home with their infants before they return to work. Infant mental health promotion activities are critical in terms of garnering broad community support and resources, and making the connection between what happens in the life of a child in the early years, and later trajectories.

Researchers from the UCLA Center for Healthier Children, Families and Communities found that by the year 2000, 76% of California parents understood that the greatest amount of brain development occurs during the first three years of life. This finding provided evidence that public awareness campaigns of the prior decade were effective given that three years prior, only 54% of parents understood the importance of the early years. However, unless universal and ongoing information and education opportunities is in place for parents to obtain this type of information, public awareness and outreach campaigns must be sustained over time to maintain their positive effects.

Relationship-Based Preventive Intervention

In addition to parents and other kinship caregivers, child care practitioners are a particularly important resource for supporting a healthy relationship between parent and child. These practitioners help *prevent* or *identify early on* any potential mental health issues by noticing risk factors and connecting families with agencies that can reduce the effects of risk. Early care and education providers are the first line of defense in promoting healthy parent-child relationships where challenges may exist. Thus, ongoing education, training and support for these front-line practitioners are essential.

Heffron describes relationship-based preventive intervention as "a way of delivering a variety of services to infants, toddlers, and families that includes a focus on the importance of parent-child interaction . . . and the deliberate use of the intervener's self-awareness in working with infants and families where relationships are at risk."

In California, these front-line workers are referred to as core providers. Core providers include early care and education providers, pediatricians, nurses, occupational therapists, speech and language pathologists, early interventionists and others who deliver services to young children.

Treatment

Infant mental health specialists *intervene* on a child's behalf when the parent-child relationship is at risk (for example, when the child has a developmental delay, a serious medical condition or the mother/primary caregiver is depressed), or when situation at home is abusive, neglectful, or otherwise harmful. Under such circumstances, these practitioners *treat* the parent-child dyad in the hopes that early intervention and treatment will lessen the impact of risky or hurtful environments or relationships.

Infant mental health specialists are the most highly trained in the infant mental health field. They come from a number of different disciplines, have advanced degrees, and typically are licensed, credentialed or certified in their profession. In the California Training Guidelines, these professionals include, but are not limited to, professionals in the mental health fields.

IV. Common Emphases of Infant Mental Health Training Programs

Relationship-Based

There is no standard curriculum for infant mental health specialists at this time, and training programs vary in content and structure. Nonetheless, there are some common areas of emphasis (Korfmacher and Hilado 2008). A core curricular element is on relationship-based work. Relationship-based work emphasizes that the development of infants and young children cannot be separated from the relationships within which their development is shaped. Zeanah and Zeanah (2009) believe this is one aspect of working with infants that is different from working with older children. Generally, according to Korfmacher and Hilado (2008), relationship based work refers "to the interdependent web in which the child develops, or more specifically to the importance of the parent-child relationship" (15). Rather than evaluating the infant alone, then, it is extremely important to pay attention to the primary caregiver and other people with frequent interaction with the infant. In addition, it is important for the practitioners to form respectful and supportive relationships with the infants' families (Korfmacher and Hilado 2008).

Attachment Theory

Most of the systems designed to train infant mental health specialists rely heavily on concepts related to attachment theory. A well-established theory in psychology and social sciences, attachment theory was developed by Bowlby during the late 1960s to 1970s. Ainsworth developed the widely-used method of measuring attachment in toddlers, dubbed "Strange Situation Procedure" and furthered the theory. The Strange Situation Procedure (Ainsworth et al. 1978) involves a series of interactions between a young child, an attachment figure, and a stranger. During the interaction, there are two separations from the attachment figure and the primary measures of attachment are assessed when the infant is separated from its caregiver and during the reunion phases with the caregiver. Securely attached children clearly express distress when separated from their caregivers, but are quick to seek comfort when the caregiver

returns and fairly easy to settle. However, children with avoidant attachment styles often show very little distress when separated from their caregivers and, upon reunion, express little need for comfort and closeness. Children with resistant (sometimes called ambivalent or anxious) attachment styles show an unusually high amount of distress upon separation from the primary caregiver and are very difficult to comfort upon reunion (Zeanah and Smyke, 2009). Finally, Main et al. (1990 as cited in Zeanah and Smyke, 2009) created the disorganized classification, which places infants at the highest risk for later psychopathology. In children with disorganized attachment, behavior during the Strange Situation is mixed and incoherent, incorporating some efforts at comfort seeking and some efforts at avoidance.

Attachment, according to Bowlby, is the development of a relationship with the primary caregiver that provides a secure base from which the infant can explore (Waters and Cummings 2000). The attachment system serves two principal functions: protecting infants from potential risks and learning to regulate negative emotions (Simpson et al. 2007). An infant with a secure attachment feels confident in the primary caregiver's availability and responsiveness, allowing the infant to explore in a variety of settings over time. The attachment relationship an infant forms with its primary caregiver in the first several months of life serves as a working model, helping to shape future expectations and experiences in relationships (Roisman et al. 2005) and future abilities to regulate negative emotions in relationships (Simpson et al. 2007). Importantly, Bowlby argued that both early and later relationships play a role in our attachment behaviors. In other words, a person's attachment style is not fixed at an early age, but can adjust due to later relationship experiences with peers and family members. Yet, Bowlby did believe that the early relationship with a primary caregiver played a central role in shaping future attachments. As Simpson et al. (2007) explain, the attachment style created during infancy sets up the child for a cascade of future attachment experiences. Thus, while people with insecure attachments are not guaranteed to continue to have insecure attachments in later life, they are more likely to develop insecure attachments to peers in childhood and adolescence, and more likely to have difficulty with attachment in adult relationships (Simpson et al. 2007).

Insecure attachment styles stem from having a primary caregiver who is emotionally or physically unavailable or unable to meet the needs of the infant. They are more likely in atypical environments such as orphanages or foster care, but can also happen due to neglect, abuse, or simply an inability to respond effectively to the infant's needs (Zeanah and Smyke 2009). Insecure attachments have important implications for the future risk of child and adult psychopathology. Having an insecure attachment has been associated with an increased risk of a variety of disorders including anxiety, dissociative disorders, disruptive behavior, substance abuse, and personality disorders. Further, as shown through a longitudinal study performed by Simpson et al. (2007), insecure attachments set the stage for difficulties in attaching to peers and to romantic partners later in life. Thus, the attachment style we form in infancy may have important implications for our ability to sustain healthy relationships as adults.

Ecological View

In addition, there is consensus that the larger social context, beyond the parent-child relationship, also has important implications for the mental health of infants. Specifically, as Bronfenbrenner's (1979) work suggests, the family context is key to early childhood emotional development. Specifically, unresolved family conflicts distress infants and young children, more so than resolved family conflicts, and undermine security (Davies and Cummings 1998 as cited in Waters and Cummings 2000). Byng-Hall (1995) suggests that the entire family should be a secure base "that provides a reliable network of attachment relationships in which all family members of whatever age are able to feel sufficiently secure to explore." Researchers are quick to point out that relationships within the family can affect the quality of the infant-parent attachment bond. For example, parental relationship quality (Goldberg and Easterbrooks 1984 and Belsky et al. 1989 as cited in Byng-Hall, 1995) has been shown to affect the quality of parent-infant attachment, as has the absence of a husband or boyfriend (Egeland and Farber 1984 as cited in Byng-Hall 1995). Further, Belsky et al. (1989 as cited in Byng-Hall 1995) found that mothers were more likely to have secure attachments with their infants if they believed their neighbors were friendly and/or helpful. Thus, while the parent-child relationship is central, it must not be forgotten that this relationship exists and can be affected by the larger social context.

Cultural and Contextual Knowledge and Sensitivity

Another competency that should be mastered by infant mental health practitioners is the understanding of diversity in terms of culture, ethnicity, and language. "Without cultural awareness, clinicians run the risk of assessing the culture rather than the infant" (Perez et al. 2002). The challenge, as posed by Bernstein et al. (2005), is to find a way to assess the parent-infant relationship in a way that is both rigorous and culturally sensitive. As Bernstein et al. point out, there are also a variety of childrearing goals, beliefs, and practices among diverse groups. Several measures of parent-infant relationships are universalist, applied equally across all ethnic, racial, and class groups. However, based on fairly recent criticisms of the universalist approach, Bernstein et al.'s article points out that many participants in the Starting Early Starting Smart (SESS) program were concerned that the universalist approach would portray poor and/or families of color as deficient or deviant rather than simply different. Participants in SESS also expressed concerns that parent-child interactions in communities of color or poor families are often interpreted as abusive or neglectful.

Working with collaborators in the SESS program, Bernstein et al. set out to evaluate a current Parent-Child Observation Guide (PCOG) (Bernstein et al. 1987) item-by-item and questioned each item's appropriateness for the various ethnic and racial groups present. Representatives from Native American, Latino, Chinese, Anglo, and African American populations worked together to develop a PCOG coding scheme that was culturally grounded. Participants also proposed site-specific alterations to the videotaping protocol, where children engage in tasks such as putting away groceries, sharing a snack, play time, and cleanup time. The PCOG has previously established reliability and construct validity for a variety of ethnic groups.

Previous research has established two factors for children – positive involvement and negative emotional expression, and two factors for parents – sensitivity and teaching. Based on feedback from Chinese participants, one of the modifications proposed by the workgroup included a wider variety of "connecting" behaviors, previously limited to eye contact, to include reaching out while not looking and orienting toward the parent in space. Native American participants suggested the inclusion of less formal teaching methods such as storytelling. Participants also proposed several culturally-specific modifications to the videotaping portion of the observation. A variety of adjustments were made to the protocol such as having tea with a Chinese parent and toddler, sharing a picnic with Native American families, and conducting the videotaping at home for Latino caregivers and children. All of these modifications were intended to reduce the effects of resistance and social desirability on the observation and make families more comfortable with the process. This is the type of cultural awareness, learned through interaction with the communities of interest, that Nugent and Brazelton (2000) called for in order to provide assessment that was responsive to the needs of parents and infants.

Bernstein et al. (2005) also point out the importance of having cultural "insiders" available to assess and observe families from a variety of racial, ethnic, and class groups. "Because of the impact of one's own culture, training, and experience, many cultural outsiders are not qualified to identify the behavioral range of maladaptive to adaptive (or poor to good) in a culture different from their own" (249). Rather, the authors argue that mainstream investigators need to involve cultural insiders in the development and revision of instruments, field testing, and interpretation of results. The authors argue that video coders should be matched to the ethnicity of the parent and child.

The issue of cultural context is particularly important in a highly diverse area such as Central California. In California as a whole, Latinos are projected to comprise 53.6% of the population by 2050. According to the July 2008 U.S. Census estimates, Fresno's population was 48.7% Latino and included more than 20% of residents who are not native to the United States (www.factfinder.census.gov). San Mateo County can serve as an example where 75% of the families served by their Pre to Three (PTT) program are Latino and many are new immigrants as well. The model presented by Perez et al. (2002) in San Mateo County includes a group that works with high-risk families (typically those who have clear indications of maternal depression) that "represents the cultural backgrounds of the families served." Thus, when developing a training model in infant mental health, there should be vigilant intentionality about training and supporting practitioners who mirror the demographics of the San Joaquin Valley.

Ippen (2009) argues that despite their best efforts to reduce growing cultural disparities, "we are failing many." Ippen reflects on her own background and suggests that infant mental health practitioners need to first reflect on their own contextual background as well, in order to fully understand the worldview of others, and how they differ. Thus, there should be open dialogue between practitioners and families to address cultural and contextual differences. While difficult, the author suggests that effective intervention is not possible without this dialogue. Dialogue with the family helps practitioners develop mutually respectful relationships and remain aware that clients may have different interpretations about whether there is a problem, what can be done, and who should intervene.

While cultural competence tends to focus on racial, ethnic, and class diversity, Ippen suggests that we should think about multiculturalism more broadly. In her eyes, multiculturalism includes being sensitive to "gender, sexual orientation, ability and disability, and religious affiliation" because these factors are also associated with common misunderstandings (2009). The author acknowledges that it is challenging to think about all these factors at the same time, and yet it is essential in order to develop appropriate assessment, intervention, and treatment/solutions. The author also suggests that practitioners be aware of contextual factors, such as transportation, financial resources, immigration status, safety concerns, family history, and future goals. Practitioners should be knowledgeable about and sensitive to historical trauma and ongoing oppression, trauma, and racism experienced by racial/ethnic groups in the U.S., particularly African Americans and Latinos. Parents of color are keenly aware of the hostile social environment of many communities and attempt to protect and prepare their children to face these harsh realities. The goal for practitioners, then, is to acknowledge there is a dialogue to be had, create a safe setting in which the dialogue can proceed, and find common ground between the experiences of parents, practitioners, supervisors, and the human service system.

Strength-Based Orientation

Further, most programs that train infant mental health practitioners include a strength-based orientation to practice, rather than focusing on deficiencies in the relationship (Korfmacher and Hilado 2008). Traditionally, mental health practitioners are trained to focus on the symptoms or signs of an illness (Greenspan as cited by Perez et al. 2002). The problem with this tendency, Shuler and Perez argue (1988 as cited by Perez et al. 2002), is that adaptive behaviors and strengths of the mother and child may be overlooked. A strength-based approach, on the other hand, focuses on the infant's competencies and adaptive abilities, while recognizing family psychopathology or problematic interactions. Perez et al. argue that a strength-based approach will help keep mother and child engaged and increase the likelihood that the intervention will help. The change in focus from deficiency to strength was spurred on in 1994 by the Zero to Three Work Group on Developmental Assessment (Greenspan and Meisels 1994 as cited by Perez et al. 2002). The Work Group proposed assessment that was an ongoing process involving the family and assessors "designed to deepen understanding of the infant and young child's strengths and resources, and of the caregiving environment most likely to help."

One example of a program using a strength-based approach is the Pre to Three (PTT) Initiative in San Mateo County, CA developed in 1996 (Perez et al. 2002:378). The PTT program involves combined efforts in the community among families who qualify for Medi-Cal coverage. Its work is focused on families that are at risk, especially due to maternal mental illness or substance abuse. But in contrast to traditional treatment approaches, the focus is not on the diagnosis of the parent or child. Of course, these issues are addressed as well. The focus is on building on the strengths already present in the infant and the relationship between the parent and infant. As mentioned earlier, the PTT team, and particularly the team that works with high-risk families, mirrors the cultural diversity of the population with whom they work. Among high-risk families, the process is broken down into five steps summarized below.

The first step in the process involves informal observation with a focus on identifying needs, available social supports, and, importantly, building a relationship with the family before formal assessment. The premise of this practice is that assessment and potential interventions will be most effective if the provider has already built a strong relationship with the entire family. The provider also informally assesses the infant's ability to utilize the resources in the environment. The second step is a more formal observation period utilizing the Family Infant Relationship Support Training tool (FIRST; Browne et al. 1999 as cited by Perez et al. 2002) for younger infants or the Parent-Child Interaction Rating Scale (Crnic et al. 1983 as cited by Perez et al. 2002) for older infants. These tools are designed to appraise the self-regulation of the infant, and the caregiver's contribution to this regulation. An individual care plan is then created with an emphasis on keeping parents (especially mothers) actively involved. During the observation period, the practitioner continues building trust and a connection in the relationship with the family. Then, there is a guided interview with the mother where she discusses her "observations, successes, and concerns" and how she was parented as a child.

Once a good relationship is formed with the family, formal assessment begins. Practitioners use the Ages and Stages Questionnaire (ASQ; Bricker et al. 1995 as cited by Perez et al. 2002) that evaluates the developmental status, competencies, and vulnerabilities of the infant. The mother is actively involved in this process and the ASQ is repeated every four months. The entire family is informed of the results. At this stage, families are referred to psychologists for more assessment and necessary interventions for the adult are completed. The fourth step is formal diagnosis of both parent and infant. Among the San Mateo County PTT high risk group, 40% of the infants met criteria for a diagnosis. Of those who did not meet a diagnosis, 45% had a mother who met criteria for a diagnosis. These families receive in-home psychotherapy or other interventions focused on relationship-building.

The final step in the process is treatment or other interventions. The strength-based model "is based on the assumption that early emotional development is contingent upon the interactions between the infant and caregiver. Treating the infant is dependent on treating the dyad; again, the *relationship* is the focus of the intervention rather than the infant him or herself. **Essentially, the goal is a secure attachment so that the infant has an organizing force in his or her life to help him or her regulate and organize so that healthy development is possible.** Importantly, the family is actively involved in designing the treatment plan. Treatments are again focused on *strengths* of the interaction as well as vulnerabilities so that the caregiver receives positive feedback for successful interactions. Appropriate referrals are given in cases where infants have developmental disabilities. Parents with mental health problems are treated in an attempt to stabilize their illnesses. In the community, the intervention aspect is accomplished by providing help with accessing health and other social services, varying from subsidized child care and in-home support to making referrals to community organizations. Strength-based approaches such as this program aim to reduce the traditional emphasis on "weaknesses" of families with mental health or substance abuse issues. Because many families could find the traditional approach stigmatizing and culturally insensitive, such an approach is a key in moving the infant mental health field forward.

Ghosts in the Nursery

Korfmacher and Hilado also point out that all systems for training infant mental health practitioners refer to the importance of "ghosts in the nursery" (Fraiberg 1980 as cited by Korfmacher and Hildao 2008). In other words, practitioners need to be sensitive to the relationship history of the caregivers, as their relationship histories have important implications for the attachment style they will likely form with their own child. The term "ghosts in the nursery" was coined by Dr. Selma Fraiberg, who, in her work doing case studies with children, realized the importance of previous generations and the traditions they created and passed on. She argued there are ghosts in every nursery, who sometimes intrude, and that is not necessarily unusual or harmful.

> But how shall we explain another group of families who appear to be possessed by their ghosts? The intruders from the past have taken up residence in the nursery claiming tradition and rights of ownership . . . While no one has issued an invitation, the ghosts take up residence and conduct the rehearsal of the family tragedy from a tattered script (Fraiberg 1980).

Thus, it is crucial that the infant mental health practitioner recognize that the relationship he or she is currently observing is the product of many relationships that came before, and the foreshadowing of relationships to come (Roisman et al. 2005).

Multidisciplinary

Perhaps what's most important for developing a training program in infant mental health is the need to be multidisciplinary in scope. Indeed, where the temptation may arise to place such a program squarely in psychology, or to overemphasize clinical approaches, one must recognize the wide array of fields that come into contact with infants and their primary caregivers. Infant mental health specialists may be trained physicians, nurses, social workers, early care and education providers, physical therapists, speech therapists, etc. Thus, the training should take into account the vast array of previous experiences and incorporate a variety of theoretical and clinical perspectives. As Hinshaw-Fuselier et al. (2009) point out, "when training extends beyond basic concepts, individualized efforts can address the different needs, perspectives, and goals of professionals from multiple fields."

Evidence-based, Acknowledgement of Perspectives, and Ethics

Three final competencies were noted by Korfmacher and Hilado as common in the systems that train infant mental health practitioners. First, practices should be evidence-based or outcome-based, meaning that they should have shown success in measurable outcomes. Second, they should emphasize the importance of seeing multiple perspectives (such as the perspective of the infant and the perspective of the caregiver). Finally, ethics are listed as a key competency in several of the systems.

V. A Glance at Training and Capacity Building Efforts in Other States

The following selected, state-level examples provide a broad overview of capacity building efforts in infant mental health.

Michigan

The Michigan Association for Infant Mental Health (MI-AIMH) offers four levels of endorsement. All four levels require ongoing membership in MI-AIMH or another infant mental health association. All levels also require signing a code of ethics and endorsement agreement. At the lowest level, the Infant Family Associate (Level 1), an associate's degree in child development or in a related area is required, or at least two years of experience working with infants and children. The training involves a minimum of 30 hours of relationship-based training, the development of a professional portfolio showcasing the achievement of set competencies through work experience and training, but no written exam. A minimum of 15 hours of additional training is required each year. Finally, there is an ongoing requirement of reflective consultation or supervision.

The Level 2 endorsement, called Infant Family Specialist, requires a Bachelor's degree at minimum, a minimum of two years post-Bachelor's work experience serving at least 10 infants and their families where the social and emotional needs of the infant or toddler are the primary foci, but relationships are also given attention. The training is similar to that of the Level 1 associate – 30 hours or enough to reach the competencies set out by the Association. However, the reflective supervision requirement is more specific, requiring at least 24 hours of post-Bachelor's, relationship-based, reflective supervision where the supervisor must have a Level 3 or Level 4 endorsement, or, in the case of a trainee who only has a Bachelor's degree, a supervisor with a Master's degree and a Level 2 endorsement. Similar to the Level 1 endorsement, Level 2 endorsees also have to obtain professional references and develop a portfolio showing competencies, but there is no written test required. Finally, the endorsee must continue an additional 15 hours of training each year.

The Level 3 endorsement, or Infant Mental Health Specialist, requires a minimum of a Master's degree, but is also available for those with an MD, DO, PsyD, or PhD. Endorsees can also have a university certificate that included coursework that is similar to the MI-AIMH competencies in infant or toddler development, family dynamics, family-centered practices, cultural sensitivity, or assessment and intervention. Similar to the other levels, 30 hours of training, or enough to meet the competencies is required to obtain the endorsement. Endorsees also need a minimum of two years of relationship-based, supervised experience in culturally diverse settings. Endorsees gain experience in both intervention and treatment working with families who may be high risk because of living patterns, parental factors that place infants at risk, infants who are already distressed, or families who are simply poorly prepared to meet the needs of their infants.

The final level of endorsement by the MI-AIMH is the Infant Mental Health Mentors specified by clinical, policy, or research/faculty expertise. The education requirements are similar to that of the Level 3 endorsement, and intensive in-service training may be used to fulfill some of the requirements. The training again involves a minimum of 30 hours of promotion of socio-emotional development or practice

in the infant mental health field. Clinical Level 4 endorsees meet Level 3 requirements for work experience but also must have at least three years, post-degree experience in practice as either a mental health supervisor, trainer, or consultant. Policy Level 4 endorsees must show at least three years post-graduate experience working as a leader or administrator in the infant mental health area. Research/faculty Level 4 endorsees must show at least three years post-graduate experience of leadership in teaching or research on infant mental health. A minimum of 50 hours of reflective supervision is required for Clinical Level 4 endorsees, but optional for policy or research/faculty endorsees.

The Michigan model has been accepted, or is under serious consideration by the following states: Alaska, Arizona, Connecticut, Colorado, Idaho, Indiana, Kansas, Minnesota, New Mexico, Oklahoma, Texas, Wisconsin and Virginia.

New Mexico

In 2003, the New Mexico Association for Infant Mental Health (NMAIMH) developed a strategic plan for training infant mental health practitioners. The plan covers everything from promotion of positive relationship to prevention and treatment for parent-child relationships that are at risk. Along with other states, New Mexico adopted the competencies and training levels created by the Michigan Association for Infant Mental Health. New Mexico describes the areas of competency as follows: theoretical foundations, law, regulation, and agency policy, systems expertise, direct service skills, working with others, communicating, thinking, and reflection (NMAIMH 2002).

The New Mexico strategic plan included six goals. First, the Association identified strengths and weaknesses in programs that already exist. This included identifying programs that utilize promising practices such as a focus on family strengths, a focus on intervening at the parent-child relationship level, emphasize promotion as well as prevention and intervention, provide reflective supervision, and work across multiple systems to incorporate services effectively. The second goal was to raise awareness among New Mexico residents of the importance of mental health during infancy. The work group planned to develop an information and marketing campaign, including a primary spokesperson and other individuals prepared to champion the cause, and produce flyers, brochures, billboards, and public service announcements that would provide a consistent message about the importance of infant mental health.

The third goal was to secure funding for researching, evaluating, and developing statewide systems for infant mental health. The workgroup first felt they needed to make more efficient use of existing sources of financial support, review the strategies of other states, and finally search for federal, state, county, and private funding sources. The fourth goal was to develop a system of ongoing support and consultation. This reflects the need for both reflective supervision and ongoing evaluation of programs to assure they are succeeding in their outcomes.

The fifth goal was to coordinate statewide efforts through such strategies as interagency agreements and facilitating coordination across systems. The system should include a full continuum of services, including promotion, prevention, and intervention that are accessible to everyone in New Mexico.

Another of the strategies is to promote the use of promising practices for infant mental health. The final goal was to establish a system to evaluate impacts of these services in order to assess their efficacy. Interestingly, one strategy discussed in the plan is to include families in the development of evaluations of the programs. The programs, according to the plan, should be evaluated on the basis of how they affect: infant-parent interaction, infant development, family support, and parental mental health. Further, programs should also be evaluated on the bases of their long term effect on health care costs.

One example of a training institute in New Mexico is the Las Cumbres Early Childhood Mental Health Training Institute in Santa Fe. Las Cumbres provides a two-year training program including bi-monthly seminars, readings, opportunities for observing parents and children, group discussion, and reflective supervision.

Vermont

Vermont's Early Childhood and Family Mental Health Competencies Practice group developed their training model in 2007. Unlike most other programs that focus on very young children, the Vermont program covers children from 0 up to age 8. Their four levels of competency are similar to Michigan's, but the educational credentials "are implied, rather than stated explicitly" (Korfmacher and Hilado 2008: 9). Foundation professionals (Level 1) are essentially all childcare providers, whether in centers or at home. The second level is intermediate professionals, which includes nurses, kindergarten teachers, and directors of childcare centers. Advanced professionals (Level 3) include mental health consultants and special education teachers. Level 2 providers should have some knowledge of the competencies developed by the practice group, and focus on being able to work with children and families who have some challenges. Level 3 providers should be able to provide consultation or direct services to the families and children with challenges. The final level is Specialist professionals such as therapists, medical doctors, agency directors, and professors. At Level 4, the competencies reflect both a deep understanding of infant mental health, as well as the skills needed for the most challenging situations and the ability to provide leadership in the field. "The Vermont system is arguably the most elaborate in terms of designating particular content for each level for all categories and subcategories of competencies" (Korfmacher and Hilado 2008).

VI. The California Training Guidelines and Regional Training Programs

In 2009, the California Infant-Family and Early Childhood Mental Health Training Guidelines Workgroup (CIF & ECMH Workgroup) released revised training guidelines and competencies for the endorsement of infant mental health practitioners (www.wested.org/cpei/forms/**training-guidelines**.pdf). The guidelines distinguish between three levels of specialists: ***core providers, infant-family and early childhood mental health specialists, and reflective practice facilitators***. At every level, providers are expected to be competent in the following areas: parenting, family functioning, and parent-child relationships; infant, toddler, and preschool development; biological and psychosocial factors impacting outcomes; risk and resiliency; observation, screening, and assessment; diagnosis and intervention; interdisciplinary/multidisciplinary collaboration; and ethics. Competencies can be learned through academic coursework, workshops and continuing education, practica, internships, or post-doctoral

training. Practitioners are also required to have clinical experience with children under 3 or families with children 3-5. They are required to engage in ongoing reflective practice facilitation. The reflective practice experiences "involve a focus on relationships, qualitative improvement, support and the investment of self in the intervention and treatment process" (CIF & ECMH Workgroup 2009). Applications to become an endorsed provider include submission of a portfolio that provides evidence of training and experience. Academic coursework is considered more rigorous than workshops or continuing education, so each hour of academic coursework counts for 1.5 hours in the application portfolio.

Core providers come from a wide variety of disciplines including occupational therapy, nursing, social work, and pediatrics. Core providers are expected to have the most frequent interaction with infants and young children and are focused primarily on promotion and prevention. They may also provide referrals to mental health specialists. The workgroup points out that core provider guidelines may also be appropriate for policymakers, advocates and researchers in the area of infant mental health (CIF&ECMH Workgroup 2009:9). Core providers are required to show evidence they have achieved the expected hours in each training domain and 120 hours of clinical experience and reflective practice. The total number of hours of coursework, clinical experience, and reflective practice ranges from 180 for an endorsement in either prenatal to three or birth to five years, to 240 hours to obtain a prenatal to five endorsement.

Infant-family and early childhood mental health specialists also represent a wide variety of disciplines. Specialists include, but are not limited to, professionals in mental health fields. "They provide prenatal, infant-family and early childhood mental health services within their scope of practice in the areas of promotion, preventative intervention and treatment" (CIF &ECMH Workgroup 2009). Specialists are expected to have obtained a minimum of a Master's Degree or some type of "license/certificate/credential" (CIF&ECMH Workgroup 2009). In addition, specialists have achieved competency in the domains listed above through coursework and have 500 hours of clinical experience/reflective practice with children prenatal to three and 500 hours with children 3-5 years old. The total number of coursework and clinical experience/reflective practice combined is a minimum of 760 hours for a prenatal to age three endorsement, or ages 3-5 endorsement only, or 1260 hours for a prenatal to age five endorsement.

The final level of endorsement is for **reflective practice facilitators**. Reflective practice involves individual or group interaction where practitioners focus on their relationships with the families with whom they work. They reflect on experiences, thoughts, and feelings, discuss parental culture and relationship experiences, and exchange ideas for working effectively with families. Facilitators are expected to embody best practice and lead the interaction. The requirements for endorsement include coursework, reading, and viewing videos on reflective practice. They also must complete a two-day training on reflective practice competencies. After the two-day training, they are then required to gain 48 hours of experience being in a reflective practice group led by another facilitator. The groups must meet face to face or through electronic means two times per month over the course of a year. It is recommended that the potential facilitator participate in two separate reflective practice groups, each lasting a year for a total of two years. Finally, they must meet with the convener of the reflective

practice group at least three times to review tapes of themselves engaging in reflective practice in order to "receive feedback about work and progress in mastering reflective practice facilitation competencies." These competencies include clarity regarding roles and ethics, understanding of interpersonal influence issues, and facilitation skills. The CIF & ECMH Workgroup Training Guidelines state that it is assumed a potential reflective practice facilitator "embraces core principles in infant-family early childhood mental health and possesses (or is far along in the process of developing) the Infant-Family and Early Childhood Mental Health Specialist competencies pertinent to his or her discipline."

The Alliant International University Infant-Preschooler Mental Health Certificate Program

Currently, there is one IFMH-focused academic training program in Central California that prepares practitioners for work in infant mental health: The Alliant International University Infant Preschooler Mental Health Certificate Program. The California School of Professional Psychology (CSPP) at Alliant International University in Fresno offers interdisciplinary training in infant and early childhood mental health culminating in the Infant Preschooler Mental Health Certificate. The courses are designed for graduate students, post-graduate mental health practitioners and others working with young children and their families. Most of the courses are offered in the evening and on weekends. The program description states that the curriculum is based on and meets the curricular requirements specified in the California Training Guidelines.

The First 5 Fresno Reflective Practice (RP) Mentor Training Program

First 5 Fresno County launched the Reflective Practice Mentor Training Program in 2009 with eight mentor trainees from different local agencies representing a number of disciplines. Over the past year, lead mentor Dr. Martha Moore and the original cohort of trainees have developed a set of recommendations for the ongoing training of RP mentor trainees in Fresno County. The plan for future implementation of Reflective Practice Mentor Training is outlined in the document "Report of Recommendations for the Regional Training and Implementation of Infant-Family Early Childhood Mental Health Reflective Practice Facilitation." In 2011, the program is enrolling three additional RP facilitation trainees.

The Napa Infant-Parent Mental Health Post-Graduate Certificate Program

Although the Napa IPMH program is based outside of the San Joaquin Valley, it is an important resource for the entire state, as well as nationally. A number of local practitioners have received training through this program. The Napa program is a 15-month weekend didactic and reflective practice experience, culminating in a post-graduate certificate conferred by the University of Massachusetts in Boston. Faculty for the program include a number of national and state level luminaries in the field of infant mental health, such as T. Berry Brazelton, Bruce Perry, Ed Tronick, and Tiffany Field, among others. The class of 2010 – 2011 included five fellows from Fresno County, and prior to that, at least two additional fellows were from Fresno. Dr. Kristie Brandt, Director of the Program and a Napa program faculty member, conducts frequent trainings in Fresno as well.

Other Degree Programs

A number of other academic degree programs at Fresno State, Fresno Pacific University, and community colleges in the region offer coursework that supports endorsement in infant mental health. These programs span the disciplines of child development, early childhood education, counseling psychology, developmental psychology, social work and others. Many of those seeking endorsement in the future will be graduates of these programs. Persons interested in the field of infant mental health need to be aware of the local resources that are available to them.

VII. Strengthening Capacity in Central California: Reflections from the Regional Engagement Process

Our region's agricultural economy, poverty, and disparities in opportunity for diverse racial/ethnic populations support the need for a community-based IFMH training program to assure high quality, culturally relevant services. Notwithstanding the value of existing IFMH training programs, there is a growing appreciation for the importance of relevant, affordable and accessible education and training opportunities for those already in the field that cover the full spectrum of infant mental health work---from promotion to specialized treatment. Further, more needs to be done to promote healthy infant-parent relationships before problems occur. If we can create an infrastructure that offers broad community education, facilitates IFECMH endorsement, and teaches the skills needed for working effectively with diverse populations, we can produce better outcomes for families.

At the beginning of this project, project leaders recognized that the history of infant mental health in the region had a number of successes under its belt, but by and large, there was disappointment that the efforts had not been sustained. In some cases there were even ill feelings about what had transpired and disappointment about the inability of the Fresno community to keep momentum and progress with the work. Many of those initially involved in the various state-supported infant mental health projects had gone on to do other work, while those still engaged with the work felt some degree of skepticism about whether appropriate training could be provided on a significant scale. Because of this skepticism, it was important to bring together some of the people who had been previously involved in the state-supported infant mental health projects to talk about that work, what was learned from it, and how things would be done differently, given another opportunity.

Thus, over the course of this project, four community conversations were convened by the CCCI. Two community conversations were held in Fresno County, one in Merced County and one in Tulare County. Attendees included those involved historically, as well as those deemed important to involve in a new phase of the work.

A. Major Themes from the Community Conversations

Fresno County

Two community conversations were held in Fresno: one in October and another in November, 2009. Approximately thirty (30) individuals participated in the two conversations, including a few who either no longer live in Fresno or who have retired. At the first community conversation, many of those attending had been involved in the state-sponsored infant mental health initiatives of the past. The second community conversation was attended primarily by those currently working with families. A major theme of both conversations was the importance of providing a space where practitioners can process their feelings about the very sad situations they were often faced with. Another theme was the challenges associated with practitioners coming from backgrounds that were different from those of their clients. Public health nurses who conducted home visits were viewed as being very important resources in this work.

When asked about what was most positive about earlier efforts in infant mental health, the response was learning labs. Learning labs were small groups that met over six or eight weeks to discuss the work and learn from each other. "It was great to have multidisciplinary involvement", said one person. There was consensus that too many of the dollar resources in those early days were being spent on the treatment end of the spectrum, and on responding to the needs of families already in the child welfare system. The importance of working on the front end to prevent problems in the parent-child relationship was stated over and over again. As another participant stated, "There simply aren't enough resources to continue to invest so heavily in treatment services, while ignoring the moral imperative to help prevent problems." There was recognition, however, that in order to shift resources from treating problems to preventing them, a well-trained workforce that can provide the many supports and services needed to make this shift must be in place.

Merced County

First 5 Merced convened a community conversation on March 3, 2010. The conversation was held at the Merced County Health Department and thirty-three (33) people attended. Many of the participants did not know each other, but were glad to learn about the great work that was going on in the county. The attendees included early childhood educators, clinicians, nutritionists, lactation specialists, parenting educators, and others.

The overall sentiment in Merced County was that the county had not made much progress in actively supporting IFMH practitioners who are doing infant-parent work. The lack of resources was believed to be a major barrier; however, there was also the sense that the medical community was not entirely supportive or perhaps did not understand the work of infant mental health. There was deep concern about the magnitude of problems facing young children and their families. The stigma associated with the term "infant mental health" was also seen as a barrier in the work.

Merced County has not experienced many opportunities to bring practitioners who work with very young children and their families together to work on a collaborative project. The benefits of infant

mental health promotion are not well understood in Merced County, particularly among physicians. Some still view our youngest citizens as "just babies," one person said. Others such as policymakers and program leaders in the community believe that the resources simply aren't there to have a lasting impact. They seem to miss opportunities to re-engineer existing programs to better support the parent-infant dyad. Concern was also expressed about the existing resources being directed to the most severe cases rather than towards broad promotion and relationship-based intervention, and that available resources are scattered and uncoordinated. There is inadequate attention being given to screening and developmental assessment such as using the Ages and Stages Questionnaire. When problems are identified, providers are reluctant to refer families to treatment services, particularly if those services are outside of the county.

One person said, "Merced County is at square one, minus three!" Another said that "Merced has a long way to go, both at the community-family-parent level, at the provider level, and everywhere in-between."

As far as key activities that would serve to move Merced County forward, participants in the community conversation believed that it's important to have a centralized place where information on infant mental health can be obtained, and to leverage existing training programs for infusing infant mental health principles. The idea of having a regional hub for sharing information and expertise was supported; however, it is unclear exactly what training resources are currently available. It isn't entirely clear at this juncture exactly who should be brought to the table. There also was concern about one agency owning the work; it was felt that a neutral entity would be best to lead the coordination effort. Several existing programs were mentioned as potential resources, including the ACCESS Program, Early Head Start, the Parenting Family Resource Center, the California Preschool Instructional Network (CPIN), UC Merced Medical School, and the Children's Roundtable.

It was mentioned that the Merced County Office of Education's (MCOE) Infant Care Program is also working to secure funds to offer training on the California IFECMH competencies. MCOE is also home to the California Preschool Instructional Network (Region 7). MCOE representatives Susan Thomas and Shirley Baltazar are leaders in this work, and they both actively participated on the Regional IFECMH Steering Committee.

Tulare County

The Tulare County Community Conversation was held June 22, 2010. Thirty-two (32) individuals attended the conversation which was hosted by First 5 Tulare County and held at the offices of the Tulare Youth Services Bureau, Inc. The group was broad and diverse, reflecting the range of infant mental health practitioners. Representatives from the Health and Human Services Agency, the courts, child abuse prevention advocacy groups, the Central Valley Regional Center, health care, Head Start, substance abuse treatment programs and others joined in the conversation. It was clear by the breadth and level of participation that Tulare County is far along in its understanding of IFMH principles in 0 – 5 work, despite not having a formal IFMH training program at this time.

First 5 Tulare County was cited as having been an important supporter of the work that had transpired thus far. The California Endowment had also supported IFMH work, having funded the Behavioral Health Collaborative in Tulare County which began to document existing services and supports. Although the inventory was never quite completed because services were constantly changing, the process of developing the inventory brought people together and fostered county-wide collaboration.

Looking back, participants felt that the Clinical Scholars program funded by First 5 Tulare and Synchrony of Visalia was a success in terms of preparing people for the challenges of infant mental health work. There was a sense that engaging a relatively small cohort of people for a year to 18 months is an effective training strategy. A leadership academy for infant mental health practitioners was suggested as a new approach for not only training and integrating IFMH concepts over time, but also for maintaining important relationships among colleagues who are doing similar work.

The Tulare County Health and Human Services Agency stressed the importance of prevention and wants to be able to help families understand what promotes wellness. They reminded infant mental health practitioners to not neglect the promotion activities of infant mental health work. One person stated that she has the sense that "the average parent in the area does not understand what IFMH is and how to access it". Another said that "there is a big difference in what a parent-child relationship looks like, and in my experience, parents lack a clue of what good parenting means." Another suggested that the region needs to conduct a public awareness campaign modeled after Kaiser Permanente's Thrive Campaign that would carry the message of "doing life better" through enhanced relationships and family strengthening.

Tulare Youth Service Bureau implemented Parent-Child Interaction Therapy (PCIT) at their Tulare site in 2007, with funding provided by First 5 Tulare County and Tulare County HHSA. PCIT is an evidence based practice for children ages 20 months to 7 years. PCIT utilizes a two-way mirror and audio/visual system to "coach" caregivers in positive parenting and relationship enhancement. With intensive training by UC Davis staff, eight therapists have been certified to date to provide this intervention. In 2010, PCIT was fully implemented at the Lindsay Family Resource Center and plans are under way to expand to Woodlake in 2011.

Synchrony of Visalia's Executive Director is a graduate of the Alliant International Infant Preschooler Mental Health Certificate program and a local leader in infant mental health. Synchrony of Visalia is also a placement location for marriage and family therapy (MFT) interns who are learning about the intersection of psychological, socio-emotional and physical health.

Commonalities across the Three Counties

A steady refrain heard in each of the counties was the need to shift more resources towards promotion and prevention. In addition to the issues presented above, the need to build stronger connections between pediatricians and other health care providers, and infant mental health practitioners was uniform across counties. Finally, there was concern about the impact of perinatal depression on the infant-parent dyad and the need to identify impaired relationships and get them help.

B. Response to the Roll-Out of the California Training Guidelines

A key requirement of this project was to disseminate the California Training Guidelines and Personnel Competencies in IFECMH to practitioners in the San Joaquin Valley, and to provide a forum for asking questions about endorsement. An event to roll-out the guidelines was held at Fresno State on December 2, 2009. Close to 150 individuals attended the seminar. Two members of the California Work Group responsible for developing the guidelines, Dr. Sue Ammen from Alliant International University and Cindy Arstein-Kerslake from the California Infant Development Association, were the primary presenters. A local panel of educators, funders and practitioners discussed the importance of the guidelines for their work.

By the end of the event, it was clear that some of those attending left without an understanding of what infant mental health is or the purpose of the guidelines. Further, the large size of the group did not lend itself to dialogue and discussion, so many left the seminar confused and frustrated that their questions had not been answered. Others did not understand how the guidelines applied to them. At the end of the day, it was clear that more work is needed to improve understanding of what infant mental health is, and the purpose and importance of endorsement.

C. Reflections from the" Nurturing the First Relationship" Conference

In April, 2010, a full-day community conference on infant mental health was sponsored by First 5 Fresno, First 5 Merced, First 5 Tulare, Fresno County Department of Behavioral Health and WestCare. The purpose of the conference was to introduce basic infant mental health concepts to a broad audience, including child care providers, parents, and faith-community representatives. Over 200 people attended the conference which was keynoted by Dr. Mary Claire Heffron of the Children's Hospital of Oakland, a nationally renowned expert in infant mental health. A panel of local experts provided an overview of early childhood mental health consultation and how it worked. That afternoon, county-specific "meet and greet" break-out groups were held.

The response to the conference was overwhelmingly positive. Conference evaluations indicated that 98% of participants found the conference to be either excellent or very good. Participants came from all over the Valley, and included students, practitioners, clinicians, K – 12 educators, as well as community college and university faculty. Again, the enthusiasm for bringing people together who either practice or teach about the work was palpable.

The conference did not meet the goal of reaching parents, faith community members and child care providers. It was apparent that a different time of day and different outreach strategies would be needed to pull in these subgroups. Nonetheless, for those who were there, there was a thirst for the information provided, and an eagerness to stay in dialogue. Participants wanted even more opportunities to meet and network with professionals in their counties who were working with infants

and their families. Offering continuing education units at a low cost proved to be important for attracting participants.

D. Infant Mental Health 101: Getting Us on the Same Page

After the Regional IFECMH Steering Committee worked together for several months, it became clear that some members of the Steering Committee assumed that infant mental health is pathology-focused and questioned the intent and rationale for doing work with babies. Others believed that their agencies were delivering infant mental health services; yet, as they described their programs, it appeared there was little emphasis on the infant-parent dyad, relationship-based therapies, or reflective practice, all of which are fundamental components. To get everyone on the same page, a three-hour presentation on "Infant Mental Health 101" was provided to the Steering Committee on September 23, 2010 by Dr. Martha Moore, a clinical psychologist in private practice and a faculty member with the Alliant International University's Infant-Preschooler Mental Health Certificate Program. Although the training was helpful for those present, many felt that more needs to be done to achieve better understanding about infant mental health, particularly by agency administrators and program leaders.

E. Feedback from the Seminar on Cultural Issues in the Practice of Infant Mental Health

Over the course of the year, there was considerable conversation about the cultural disconnects that exist in the local delivery of infant-family mental health services. Concerns were articulated about the lack of representation of communities of color (Latino, African American and Southeast Asian) as practitioners, leaders and faculty of IFMH programs. Practitioners expressed concerns about their skill sets for working with culturally diverse populations. There were also a number of scenarios that arose during the project that reflected a lack of cultural knowledge and sensitivity.

As a result, Dr. Barbara Stroud, a clinical psychologist and graduate fellow of Zero to Three, was invited to conduct a seminar on "Cultural Issues in the Practice of Infant Mental Health" in October, 2010. The seminar was attended by 75 practitioners from five counties in the San Joaquin Valley. Participants rated the event very highly in terms of satisfaction; however, there were a number of conversations after the event about how the seminar merely scratched the surface of the deep hurts and concerns that exist about race and culture in the Valley as they relate to working with children and families. Clearly, there is a need for ongoing training and dialogue in this area, as well as a container for honest dialogue about racism and cultural bias and its effects on our work with families.

F. Regional Planning: The Infant-Family Early Childhood Mental Health Steering Committee

The Regional IFECMH Steering Committee was composed of 35 representatives from Fresno, Madera, Merced and Tulare counties. Membership on the Steering Committee was open and voluntary. The group met from April through December, 2010. The group members represented varied levels of involvement with families and a diversity of perspectives. Members included direct service providers, clinicians, university faculty, program managers, hospital representatives, and others (see Appendix). Initially, about 25 individuals were asked to serve; however, the group grew in size as enthusiasm and

buzz about the project increased. Steering Committee meetings were hosted by St. Agnes Hospital, Exceptional Parents Unlimited, West Fresno Regional Center and the Central Valley Regional Center.

The Steering Committee was charged with dialoguing and reaching consensus about how training in IFMH would be structured in our region, as well as ways to attract a more diverse workforce. Three subcommittees were created: Agency Training, Curriculum, and Pipeline. The committees were chaired or co-chaired by Freda Kaprelian and Shirley Baltazar (Agency Training Committee), Shanna Wilson and Dr. Daryl Hitchcock (Curriculum Committee) and Dr. Cassandra Joubert (Pipeline Committee). The committees met several times over an eight-month period. They discussed how training is currently being accomplished in the Valley and that there is a lack of coordination and leveraging of resources. They talked about what practitioners in the field need to know to do their jobs better. They also talked about the importance of reflective practice and how it was being done.

The Steering Committee's deliberations proved invaluable for dissecting and better understanding the issues, as well as hearing multiple, and sometimes divergent perspectives. These deliberations, as well as what was discussed at the community conversations, and the feedback and participant evaluations from the three large events, culminated in the recommendations presented below. Those who participated in this project are eager to see some the proposed ideas come to fruition.

VIII. Recommendations for Prioritizing Infant Mental Health Promotion, Strengthening Relationship-Based Preventive Intervention, and Assuring High Quality Treatment

A. <u>Recommendations from the Regional IFECMH Steering Committee</u>

The following recommendations address community needs for education and training of parents, paraprofessionals, core providers and specialists in the areas of promotion, and relationship-based preventive intervention and treatment. These recommendations lay the groundwork for several tasks that should follow, including:

- ongoing planning to identify leadership for the various proposed efforts
- selecting priorities for moving forward;
- exploring opportunities to leverage existing activities that would support the work;
- identifying possible funding sources; and
- establishing a mechanism for monitoring and evaluating progress on each recommendation.

First 5 Fresno has already begun to provide leadership and to implement a number of the activities recommended below; as such, these recommendations simply lend support to many efforts already in progress. However, a number of the recommendations involve developing new programs or activities, and will require further discussion and refinement.

1. Expand opportunities for community education to support family wellness and infant mental health

Since the establishment of First 5 Commissions around the state, a number of public awareness and community education efforts about the importance of the first five years have been launched. We should determine to what extent these awareness activities are being sustained, and whether they specifically address the importance of early relationships. Also, we need to ask whether these efforts are reaching families and communities where the need for information is likely to be greatest due to high rates of poverty, language barriers, teen parents, and lack of access to needed services.

Community education classes offered through Fresno Adult School's Cesar E. Chavez Adult Education Center provide an opportunity to reach young adults and parents with young children. Doctor's offices, schools, child care centers, county offices and faith-based organizations are also potential community locations for disseminating information about the importance of early relationships. Agency newsletters, public service announcements and radio for monolingual populations might also be involved in an awareness campaign. By working with communications experts and media specialists, and with service providers, the best way to deliver messages to target audiences should be determined, including utilizing new forms of media such as social networking sites and text messaging.

2. Expand parenting education programs and assure that existing programs include a focus on the early years, and the importance of early relationships

Parenting education programs are a great tool for promoting awareness of the importance of relationships on brain development, and for teaching parents how to engage with their babies in ways that enhance their socio-emotional development. First 5 Merced County currently supports the Parent As Teachers program. This program includes a home visitation component and is offered in a number of school districts.

First 5 Fresno County, in cooperation with the Children's Service Network (CSN) and the Central California Children' Institute (CCCI), will be conducting an inventory of parenting programs in Fresno County over the next year to determine opportunities for expansion, audiences being reached, and unmet needs. Once parenting education resources are identified through this process, the CCCI should examine the extent to which existing programs offer a relationship-based perspective, and if necessary, identify new parenting programs for implementation that incorporate this content. A similar examination might be conducted in Tulare County.

3. Create a more culturally diverse infant mental health workforce

The Central Valley region is very diverse with at least 40% of the general population being Hispanic, 11.2% Asian and 8.4% African American. According to kidsdata.org, 58.7% of the child population in Fresno County is Latino, 9.4% are Asian/Pacific Islander, and 5.2% are African American. College graduation rates among populations of color in the San Joaquin Valley are considerably lower than for whites. Presently, endorsement in infant mental health requires a minimum of a bachelor's degree; and

because of low college graduation rates, Latinos, Southeast Asians, and African Americans are likely to be underrepresented in the endorsement process as it currently exists.

The California Work Group is currently developing a plan for endorsement of early care and education providers. This will open the door for creating a more diverse and well-trained infant mental health work force. In addition, there also needs to be an intentional, well-implemented strategy to increase diversity in the IFMH pipeline and encourage the upward mobility and equitable participation of Latino, African American and Southeast Asian practitioners in the field. An Infant Mental Health Leadership Academy (or similar type program) designed for Latino, African American and Southeast Asian college and graduate students in child development, early childhood education, psychology, etc. could be a short term strategy for raising awareness about the field of infant mental health for underrepresented groups, for attracting future professionals into the field of infant mental health, and shepherding them towards endorsement.

4. Ensure a strong curricular emphasis in IFMH training on issues related to cultural bias and reducing racial micro-aggressions

The overrepresentation of children of color in the child welfare system, coupled with anecdotal experiences of racism and cultural bias experienced by families, suggests a strong need to train practitioners to be more culturally competent and family-centered. Because practitioners may be blind to their cultural biases, opportunities for honest and constructive feedback and conversation about racial micro-aggressions is desperately needed.

Often, conversations about cultural bias can be tense and/or dismissive. The leadership group designated to implement the proposed training recommendations should consider hosting a required training for all faculty affiliated with the training hub. It would be important to identify trainers and facilitators for this training who can hold a container for the delicate conversations that are likely to ensue.

5. Infuse child care provider training programs at community colleges with IFECMH content

In California, the child development permit and an Associate's Degree in child development are two primary credentials required to work in child care settings. Many young children in our region are in the hands of these child care workers each day. Besides parents and other family caregivers, these paraprofessionals are most likely to have regular contact with young children and their parents. Therefore, infusing didactic and experiential IFECMH content into the child development permit and/or the Associate level training programs at community colleges in our region could go a long way in reaching families with this information.

With First 5 Merced County support, the REACH (Raising Early-Intervention Awareness for Children's Health) program at Merced College has infused screening and early intervention content into child development and nursing course content.

Aside from Merced College, at least five other community colleges in our region provide paraprofessional training programs in child development: College of the Sequoias, Fresno City College, Merced College, Porterville College, Reedley College and West Hills Community College Coalinga. It is recommended that interested faculty and administrators from these programs be convened to discuss opportunities for infusing IFECMH content into their curriculum, and determine the necessary steps for making this happen. It was also suggested that an IFECMH certificate program be explored for implementation within community college early intervention or child development programs.

6. Explore opportunities to infuse infant mental health content into existing four-year academic programs

While establishing a community-based training program is paramount, it is also important that university-based programs in our region offer students content in infant mental health as a part of child development, early childhood, psychology and other curricula. A Task Force should be established to determine how the infusion of infant mental health into existing four-year college coursework can occur. Some faculty members are already infusing their classes with this content, and in other cases, universities are adding infant mental health courses as part of their degree programs; however, local experts in the various domains of knowledge in the California Training Guidelines could come together with interested university faculty to take this idea to scale. This strategy could also create opportunities for co-teaching of infant mental health-related courses by practitioners and university faculty, thereby strengthening the classroom experience and fostering collaboration among community agencies and academic institutions.

During the course of this project, faculty members at Fresno State expressed an interest in establishing a certificate program in infant mental health that would be offered through the Division of Global and Continuing Education. Although there was agreement among the IFECMH Steering Committee members that creating another university-based program is not the top priority at this time, the region should take advantage of Fresno State's interest and support them in this effort if possible. Fresno State is recognized federally as a Hispanic-serving institution. It has considerable capacity to not only attract Hispanic students to the field of infant mental health, but also to leverage the university's resources for this purpose.

7. Expand programs to enhance the capacity of early care and education providers and parents to promote the socio-emotional well-being of young children

It is important to engage both center-based and family child care providers in training opportunities that enhance their ability to promote the social and emotional well-being of young children. The Social and Emotional Foundations for Early Learning Program (SEFEL) is one program designed to promote provider competency in this area. SEFEL is currently being used by a number of agencies in Merced County, including Head Start, Merced College Child Development Center, and Merced City School District's Preschool Program. Discussions about implementing the SEFEL program in Fresno County are in the early stages of research and discussion.

The Program for Infant-Toddler Care (PITC) and Touchpoints are already underway in Fresno County. PITC provides a framework for relationship-based approach in infant-toddler programs. Touchpoints is a practical approach for enhancing the competence of parents in meeting their child's developmental needs. Opportunities to expand these programs should be explored. A partnership between Fresno, Merced and Tulare counties to deliver these programs could reduce overall costs and maximize training dollars.

8. Promote endorsement in infant mental health by providing additional opportunities to learn about and discuss the California Training Guidelines and the endorsement process

Knowledge and understanding of the California Training Guidelines in the tri-county area remains sparse. Many of those attending the December 2009 roll-out of the guidelines indicated that many questions remained for them, as well as unclarity about the procedures for becoming endorsed. Now that the California Center for Infant-Family and Early Childhood Mental Health (housed at the WestEd Center for Prevention and Intervention) has been established as host to the endorsement process, more information is available for dissemination to practitioners interested in pursuing endorsement.

The Infant Development Association of California is working closely with WestEd and the California Center to provide information about the endorsement process in communities around the state. IDA leaders have asked Fresno to host a webinar on the guidelines in the spring of 2011. This would be a good opportunity for people in the region to learn more about the guidelines and to strengthen our connections with the California Center. Even beyond the spring, however, information about the Training Guidelines and the endorsement process needs to be disseminated throughout the region on an ongoing basis.

9. Create a regional, community-based IFECMH training hub

A major goal of this project was to determine an appropriate model for training infant mental health practitioners in our region. The merits of a university-affiliated versus a community-based training program were discussed, as well as what was already available in the region and state. The Regional IFECMH Steering Committee decided that a program for practitioners already in the field that firmly integrates didactic training with reflective practice was needed. Those who had previously matriculated in academic programs recalled how these programs provide important theoretical foundations; yet, once professionals are in the field and working with families, they found themselves ill-prepared to deal with many of the challenges they had to face in their work. For this reason, the Regional IFMH Steering Committee recommends that a training hub be developed that allows for a didactic experience, true cross-disciplinary interaction and learning, and reflective practice as a process for integrating theory into daily practice. Because the small group experiences provided by the learning lab approach were remembered so favorably, it was agreed that we should re-establish these groups as the primary structure through which learning would occur.

Establishment of these small groups would be the responsibility of the hub. Another key function of the hub would be to calendar and coordinate agency trainings that are offered in the tri-county area, and to disseminate this information so that these opportunities can be shared. Many local child-serving

agencies such as Exceptional Parents Unlimited and KC Kids currently offer training opportunities for their staff in infant mental health. Some of these trainings include a reflective practice component, others do not. To maximize dwindling resources and encourage cross-disciplinary, reflective and interagency learning, the hub would disseminate information about these trainings to practitioners in training, and document the training hours and/or CEUs that can be counted towards endorsement and/or other certification, as well as continuing education units after endorsement is achieved. The hub would provide leadership and support for the small groups, or pods, that would bring practitioners together from multiple disciplines, racial/ethnic backgrounds, and levels of engagement with families.

It would also be the hub's responsibility to identify gaps in training being offered as it relates to the training domains required for California endorsement in infant and early childhood mental health, and to sponsor additional lectures, seminars and workshops. These training opportunities could be supported via collaborative funding arrangements between First 5 organizations, county departments of behavioral health, county offices of education, regional centers and others.

Ongoing and rigorous process and outcome evaluation of the proposed training hub should be crafted at the outset to assure its programs are meeting the ongoing needs of participants, and that the goals of being multidisciplinary, family-focused, culturally sensitive, and locally relevant are being achieved.

The Reflective Practice Mentor Group (RPMG) has submitted a proposal to First 5 Fresno County that offers more detail as to how a hub (referred to as the Central Training Collective), learning pods and reflective practice might be implemented in Fresno County. For these recommendations, please see pages 32 - 37.

10. Engage a representative group of agency directors/administrators from local child-serving agencies as an advising body to outline the training curriculum, recommend faculty, and determine training priorities

An important concern expressed by agency leaders over the past year is that training in IFMH must be tailored and responsive to the unique needs of individual family-serving agencies. Therefore, if didactic training in our region is to be coordinated and shared, a broad range of agencies and entities offering those trainings should be included in conversations about content, faculty, etc. Also, local agency leaders should be engaged in the process of recruiting and supporting trainees for participation in the learning pods.

11. Create a local/regional chapter of the Infant Development Association as a way to connect IFECMH practitioners with each other for both networking and learning across the region

There is very strong interest in establishing a mechanism for regular communication and networking among infant mental health practitioners in the region. A pilot webpage for this purpose was established at www.centralcaliforniachildren.org; however, the response to this web-based mechanism was not strong. It was subsequently suggested that a local chapter of the California Infant Development Association be pursued, as well as a chapter of the World Association of Infant Mental Health for those interested in connecting with infant mental health practitioners around the U.S. and beyond.

As mentioned above, IDA –California is working collaboratively with WestEd to facilitate endorsement in IFMH, and its annual meeting has become an important training opportunity for people from around the state who work with infants. Currently, more than 25 counties, including San Joaquin Valley counties, are a part of the River Valley region of IDA-C. If sufficient interest is generated, a smaller subset of counties in the San Joaquin Valley might join together to create their own chapter. This smaller chapter would be more attractive to individuals in our region, as there could be greater focus on tackling issues and concerns that are unique to the San Joaquin Valley. Based on initial conversations, IDA-C is willing to consider creating a San Joaquin Valley chapter and is eager to meet with local leaders to outline the necessary steps.

B. <u>Recommendations from the First 5 Fresno Reflective Practice Mentor Group</u>

The First 5 Fresno Reflective Practice Mentor Group (RPMG) was formed in 2009 to provide training in reflective practice facilitation. After working together for more than a year, the Mentor Group developed a set of recommendations regarding how training in reflective practice should be structured in Fresno County. In November, 2010, the RPM group released a *Report of Recommendations for the Regional Training and Implementation of Infant-Family Early Childhood Mental Health Reflective Practice Facilitation (2010)*. Overall, the RPMG recommendations are consistent with recommendations of the Regional IFECMH Steering Committee, and provide additional detail as to how a centralized training program might be structured, as cited below:

> *"It is recommended that a central, training collective be created and housed at First 5 Fresno County and that First 5 act as the primary host of the training collective. The Central Training Collective is recommended to be a free-standing entity that is not affiliated with one service or training institution. It is recommended that the Collective be "housed" in a program such as First Five, but that it then also have built-in buffers between this funding agency's program officers and evaluators which would allow potential trainees and practitioners/agencies in search of professional and service development a sense of 'protected status' when in RPF or other training and support settings that encourage free communication about problematic work situations. The creation of a buffer would allow participants to talk about troublesome issues without fear of putting funding or future funding in jeopardy. Creation of a buffer might be as simple as making sure that boundaries and organizational practices related to this issue are clearly defined in all training venues.*
>
> *History has shown us that there exists a high level of fear within agencies funded by First 5, and other large central agencies in our region, that there might be retribution by the funders should it be discovered that every day is not exactly a perfect day at the program being funded. While continued improvements in relationship-based and reflective communication practices between all agencies in our region may gradually serve to alleviate fears over time, in the short term, this is an issue which merits the development of supportive and adaptive organizational practices and structures.*

It is also recommended that the potential for additional sources of funding be explored. The Irving B. Harris Early Childhood Mental Health Training Program at Oakland Children's Hospital in Alameda County has had a great deal of success in reaching out to potential IFECMH practitioners in the community by offering an IFECMH and RPF-focused curriculum in an affordable and realistic manner. The Irving B. Harris Foundation, which supports the Alameda County program, and other funding organizations might be approached by leaders in our community to explore the potential for gaining further support for the development of the recommended training collective.

The Central Training Collective as Home to the Following Services

Within the training collective, the agency leader, practitioner or other community member might find a wealth of training and support services focused on the needs of young children and their families and the various agencies within the community which support them. It is suggested that the Training Collective become a home, or collecting space, for the following IFECMH-based services and entities. The entity names were developed by members of the RPF Mentor group as a means to describe key types of supporting IFECMH practitioners in our community and by no means represent designations actually coined by the Training Guidelines. Services and entities to be housed within the collective will be described in the following sections.

Central Training Collective as Home to the Facilitating Mentor

The 'Facilitating Mentor' is an IFECMH Level III Mentor-Trainer Specialist who would be housed at the collective by means of registration and regularly scheduled meetings, RP groups, and/or trainings. (This would not be a position of employment, but rather a designation which would be eligible for particular types of funded or non-funded work or committee participation.) The Facilitating Mentor would have the highest levels of training and expertise in both RPF and IFECMH knowledge bases, professional competencies, and clinical experience. Facilitating Mentors would reflectively facilitate RPF-MTs who are currently training new facilitators and would be working with RPF-MTs to coordinate appropriate IFECMH trainings relevant to needs of groups and portfolio development/endorsement needs. They would monitor regional RPF-FiT and RPF groups and evaluate progress and quality assurance. Facilitating Mentors would also act as consultants to agencies and facilitators in need of support around difficult RP issues which require more intense attention.

Finally, Facilitating Mentors would form a committee which might also include key leaders in the IFECMH community. This committee would evaluate programs and practices which are being brought into the region towards their potential effectiveness; fit with IFECMH model integrity; demonstration of best practices; and potential for integration with pre-existing programming; and capacity for collaborative practices. The evaluation results and recommendations would be offered to funding agencies as a means of supporting development of integrated IFECMH services grounded in best practice.

In this way, the collective training center would allow a place for new and old programming to be evaluated in the context of IFECMH theory and practice as it is embraced in our region. CSEFL, Touchpoints, PITC, and so forth would be examined in this context and in the context of how a bridge from our RPF and IFECMH structures to these new program structures could be built to ensure that new programs fall into RPF groups so that quality and integrated practice is insured and maintained.

Because Facilitating Mentors would be in close connection with RPF-MTs via regularly scheduled mentor groups for mentor-trainers who are leading RPF facilitator training groups, they have their finger on the pulse of current needs and issues coming up in groups and agencies across the region at all times. Facilitating Mentors have the capacity to collect this information which is crucial to the development of new support services and training modules. They would then collaborate with others to develop new training or professional development experiences that reflect the needs and preferences of actual agencies and professionals in the region.

Central Training Collective as Home to the Clinical Scholar

The IFECMH 'Clinical Scholar' is a designation given to an IFECMH practitioner, researcher, or academic who has demonstrated expertise in a particular area of the knowledge bases or professional competency domains. This would be expertise, grounded in practical experience, that is above and beyond typical levels of training and experience. The Clinical Scholar would not only demonstrate excellence in the specific subject matter, but would be capable of utilizing the reflective learning process and modes of presentation that are palatable to the population attending the training.

It is recommended that a 'search committee,' or perhaps the committee formed by Facilitating Mentors, explore the region for clinical scholars on a wide variety of knowledge and practice topics and develop a reference list to be keep on record at the Training Collective for professionals and agencies to use when they find that they require training in a particular area. This would be a veritable 'library' of resources for our region. Furthermore, once new training and support needs are identified via the continual interactive process generated by RPF groups, it would be a fairly simple practice to look up a clinical scholar and begin to collaborate with that person about the development of a needed training.

Central Collective as Home to the Visiting Clinical Scholar

The Central Training Collective would also be a temporary home for the 'Visiting IFECMH Clinical Scholar.' The Visiting Clinical Scholar would be those noted professionals in the field of IFECMH who might be invited to the region for larger trainings on important IFECMH area of interest. Again, the Facilitating Mentor Committee might work with key IFECMH leaders in the region to identify potential visiting scholars and invite them to the region for topical trainings that are representative of current areas of need/interest in the community. (The Facilitating Mentors will have current information on training needs given their relationship to RPF leaders and members.) Should particular knowledge domains of the Training Guidelines be identified as

needing attention by large segments of the community, one alternative for training might be to explore the possibility of employing a Visiting Scholar. Once Visiting Scholars were invited to the region, the committee would meet with them to collaborate and structure trainings along reflective learning guidelines and to design related 'mini-pods' of reflective learning to take place in RPF groups once the Visiting Scholar has completed his training.

Central Collective as Home to the RPF Facilitator Registry

It is recommended that the Central Training Collective become a central registry and collecting space for training and support of Reflective Practice Facilitators who are in the training process and who are actively engaged in the practice at Levels I, II, or III. Those Core Providers or Specialists who have been trained and facilitated to become RP group facilitators and who have been endorsed by the Workgroup would be kept on file in a registry at the Central Training Collective so that agencies or private practitioners in need of RPF training and support might easily access a trained, endorsed IFECMH professional.

The collective would act as the central hub for training and facilitation of potential facilitators; as well as the central place for previously trained facilitators to return for regular RPF with RPF-MTs or for RPF-MTs to return for regular RP Mentor Groups. The collective would also be the central place where these potential facilitators apply and are evaluated for "goodness of fit" for the role of facilitator before receiving the training and facilitation.

Central Collective as Home to Reflective Practice Facilitation

It is recommended that the Training Collective provide the center for reflective practice training for RPF; for facilitation for facilitators; for information and consultation with agencies considering integrating RPF within their organizations; and for a central registry of RPF groups in the community which may be available for those looking for a group to join in order to get facilitation of clinical experience for endorsement or for professional growth and support.

The Collective as Home to the 'Endorsement Bank and Trust'

One of the difficulties encountered in beginning to institute RPF in the region has been that our community lacks sufficient numbers of IFECMH endorsed or endorsable practitioners. It has been recommended that a key part of RPF training be IFECMH portfolio development towards endorsement for all trainees and that the institution of RPF in our community also be employed as a major vehicle for training in the knowledge bases and professional competencies proposed by the Training Guidelines. Towards this goal, it is recommended that a sort of 'Endorsement Bank and Trust' would be developed, at the Collective, wherein practitioners would keep records of training completed; receive support and advisement for developing a portfolio and training plan; and be able to publicly register as an endorsed practitioner within a particular discipline.

It would be a central place to find out what training is needed; when regularly scheduled training by RPF-MTs, on various categories in the knowledge domain of the IFECMH Training Guidelines,

would be next available via the 'learning pods' curriculum suggested in a later section; and when other trainings might be available in the near future via Local or Visiting Clinical Scholar programming.

<u>The Collective as Home to the 'Learning Pod'</u>

This report has recommended that RPF, RPF-FiT, and RPF-MT groups alike are excellent containers and mediums for on-going IFECMH training toward developing portfolios that would lead to endorsement as Core Providers or Specialists for all practitioners in our region. Furthermore, it has been noted that for the trained and endorsed practitioner to be able to keep up to date on best practices and to maintain appropriate support for IFECMH interventions and practices, the professional must participate in on-going training and RPF throughout his career. The RPF Mentor Group has developed and recommends the concept of the RPF group as a "Learning Pod" to be led by trained and endorsed facilitators, who are themselves also participating in RPF-FiT groups led by RPF-MTs or Level III Mentor-Trainer Specialists.

It is recommended that as Phase III is developed, the implementation of RPF groups as "Learning Pods" be instituted. The designation, "Learning Pod," refers to RP groups which have as a part of their structure both regularly scheduled periods of RPF time given over to reflective learning opportunities to occur within the group and intermittently scheduled larger trainings which bring many RPF group memberships together for a combination of small and large group reflective learning experiences several times a year. This pattern of training is described in Section 7.4.c of this report, but in Phase III would be focused on training related to IFECMH knowledge and professional competency domains, rather than on RPF knowledge and competencies training needed in Phase II. All "pods" of training would be developed out of the IFECMH knowledge bases and professional competencies curriculum and would be co-created by Facilitating Mentors, RPF-MTs, and local and visiting clinical scholars.

For example, in a 12-month period of RPF implementation, it might be possible for a group of practitioners to achieve 4, five-hour large-group trainings on salient IFECMH topics required for the endorsement process. (These larger trainings would then be brought back to the 'learning pods' for further reflective learning opportunities.) Each RPF group, it is recommended might also be structured to that every other RPF meeting be used as a reflective learning opportunity on a particular piece of the curriculum so that the "pod" would allow for 1 hour of training every other week. In a year's time, the practitioner who is participating in weekly RPF groups would have potentially achieved close to 45 hours of training towards portfolio development. A core provider who needs a total of 120 hours training per endorsement guidelines would have the very reasonable expectation of achieving her goals within a period of three years. (The Specialist requires much more training, so the estimate of time using this particular plan would need to be doubled.) "

IX. Project Evaluation and Next Steps

Through this project, a great deal has been learned about the history and current status of infant mental health training in our region, the interests, concerns and training needs of practitioners doing this work, and the opportunities for strengthening the region's capacity in the future. Recommendations that support greater investment in infant mental health promotion activities have been proposed, as well as guidelines for developing a community-based training program. These recommendations have received support from either the Regional Infant Mental Health Steering Committee or the First 5 Fresno County Reflective Practice Mentor Group, and in some cases, both.

At its December, 2010 meeting, members of the Regional IFMH Steering Committee were asked to speak about the impact that the 15-month long project had upon them and/or their work. The response was that the "how" to do training was more clear, hopefulness about fulfilling the dream of a community-based training program was stronger, and that there was pride that the region had worked so well together to spread the message about the importance of infant mental health. Having service providers, child care providers, faculty, and agency administrators work together along this journey was inspiring, and helps move us towards common goals and a common language in the work we do.

We agreed that the next step is to develop a work plan for carrying the recommendations forward. In developing this plan, the following questions would be considered:

1) What programs will be the top priority for either implementation or expansion over the next three years?
2) How do the proposed programs fit or align with related programs in the tri-county area?
3) What opportunities for funding exist to support these priorities, and how can additional funding be leveraged?
4) What type of staffing structure and leadership body will be put in place to further define and implement the recommendations contained in this report?
5) What is the role of the Regional IFECMH Steering Committee going forward and how will its momentum be maintained?
6) To what extent will the three counties (Fresno, Merced and Tulare) continue to work together to implement the recommendations contained in this report, and what will be their respective contributions to the effort?

We have great opportunities before us. Let us celebrate what we have accomplished thus far, and recommit ourselves for the hard work ahead.

REFERENCES

Ainsworth, Mary D. Salter, Mary C. Blehar, Waters, Everett, and Sally Wall. 1978. *Patterns of attachment: A psychological study of the Strange Situation.* Hillsdale, NJ: Erlbaum.

Bernstein, Victor J., Percansky, C., & Hans, S. L. 1987. "Screening for Social–emotional Impairment in Infants Born to Teenage Mothers". Paper presented at the biannual meeting of the Society for Research in Child Development, Baltimore, MD.

Bernstein, Victor J., Elizabeth J. Harris, Claudia WeLaLa Long, Elizabeth Iida, and Sydney L. Hans. 2005. "Issues in the multi-cultural assessment of parent–child interaction: An exploratory study from the starting early starting smart collaboration." *Applied Developmental Psychology* 26: 241-275.

Bronfenbrenner, Uri. 1979. *The ecology of human development*. Cambridge, MA: Harvard University Press.

Byng-Hall, John. 1995. "Creating a Secure Family Base: Some Implications of Attachment Theory for Family Therapy. *Family Process* 34:45–58.

California Center for Infant-Family and Early Childhood Mental Health. Why Do We Need Competencies for Infant Family and Early Childhood Professionals in California? (Available at www.ecmhtraining-ca.org/endorsement.html)

California Infant-Family and Early Childhood Mental Health Training Guidelines Workgroup. 2009. *Revised Training Guidelines and Personal Competencies for Infant-Family and Early Childhood Mental Health*. California's Infant, Preschool, & Family Mental Health Initiative, 2003. Retrieved August 19, 2009. (http://www.wested.org/cpei/forms/training-guidelines.pdf)

The Cathie Wright Center for Technical Assistance to Children's Systems of Care. 2002. "CWTAC Updates: Series on Infant and Early Childhood/Family Mental Health." *CWTAC Updates* 5:1-10. Retrieved September 1, 2010. (http://www.cimh.org/downloads/CWTACJuly-Aug02.pdf)

Conlon, Bridget. Infant Mental Health: A Review of Concepts, Common Practices and the California Guidelines, 2010.

Center on the Social and Emotional Foundations for Early Learning. n.d. "Research Synthesis: Infant Mental Health and Early Care and Education Providers." CSEFL, Childcare Bureau, and Office of Headstart.

Fraiberg, Selma. 1980. *Clinical Studies in Infant Mental Health: The First Year of Life.* New York: Basic Books, Inc.

Goodman, Sherryl H. and Brand, Sarah R. 2009. "Infants of Depressed Mothers: Vulnerabilities, Risk Factors, and Protective Factors for the Later Development of Psychopathology." Pp. 153-170 in *Handbook of Infant Mental Health,* edited by Charles H. Zeanah, Jr. New York, NY: The Guilford Press.

Ippen, Gosh and Michiko, Chandra. 2009. “The Sociocultural Context of Infant Mental Health.” Pp. 104-119 in *Handbook of Infant Mental Health,* edited by Charles H. Zeanah, Jr. New York, NY: The Guilford Press.

Heffron, Mary Claire. 2000. “Clarifying Concepts of Infant Mental Health – Promotion, Relationship-Based Preventive Intervention, and Treatment.” *Infants and Young Children,* 12 (4): 14, 21.

Hinshaw-Fuselier, S., Zeanah, P. and Larrieu, J. 2009. “Training in Infant Mental Health.” Pp. 533-548 in *Handbook of Infant Mental Health,* edited by Charles H. Zeanah, Jr. New York, NY: The Guilford Press.

Korfmacher, Jon and Hilado, Aimee. 2008. *Creating a Workforce in Early Childhood Mental Health: Defining the Competent Specialist*. Herr Research Center for Children and Social Policy Research Report. Chicago, IL: Erikson Institute.

Moore, Martha. Report of Recommendations for the Regional Training and Implementation of Infant-Family Early Childhood Mental Health Reflective Practice Facilitation, 2010.

New Mexico Association for Infant Mental Health. 2002. “New Mexico Association for Infant Mental Health Endorsement for Culturally Sensitive, Relationship-Based Practice Promoting Infant Mental Health.” Retrieved January 13 2011. (http://www.nmaimh.org/RS_Cdefn_6.5.08.pdf)

Nugent, J.K, & Brazelton, T.B. 2000. “Preventive mental health: Uses of the Brazelton Scale.” in *WAIMH Handbook of Infant Mental Health*, edited by J. Osofsky & H. Fitzgerald. New York: Wiley.

Perez, L. M., Peifer, K. L. and Newman, M.C. 2002. “A Strength-Based and Early Relationship Approach to Infant Mental Health Assessment.” *Community Mental Health Journal* 38:375-390.

Richardson, Nancy M. History of Infant Mental Health in Fresno County (2009).

Roisman, G., Collins, Andrew, Sroufe, L. Alan, and Egeland, Byron. 2005. "Predictors of Young Adults’ Representations of and Behavior in their Current Romantic Relationship: Prospective tests of the Prototype Hypothesis.” *Attachment and Human Development* 7:105-121.

Simpson, Jeffry A., Collins, A., Tran, S. and Haydon, K.. 2007. “Attachment and the Experience and Expression of Emotions in Romantic Relationships: A Developmental Perspective.” *Journal of Personality and Social Psychology* 92:355-367.

UCLA Center for Healthier Children. Families and Communities, Series on Building Community Systems for Young Children. Halfon, N., Shulman, E. and Hochstein, M. “Brain Development in Early Childhood”, August 2001.

Waters, Everett and E. Mark Cummings. 2000. “A Secure Base from which to Explore Close Relationships.” *Child Development 71*:164-172.

Weatherston , Deborah J., Melissa Kaplan-Estrin, and Sheryl Goldberg. 2009. "Strengthening and Recognizing Knowledge, Skills, and Reflective Practice: The Michigan Association for Infant Mental Health Competency Guidelines and Endorsement Process." *Infant Mental Health Journal* 30:648-663.

Zeanah, Charles H. and Zeanah, Paula D. 2009. "The Scope of Infant Mental Health." Pp. 5-21 in *Handbook of Infant Mental Health,* edited by Charles H. Zeanah, Jr. New York, NY: The Guilford Press.

Zero to Three Policy Center. Building System Capacity: Improving Infant and Early Childhood Mental Health in Philadelphia, March 2006.

Zero to Three Infant Mental Health Task Force. 2002. "What Is Infant Mental Health?" Retrieved September 1, 2010. (http://www.phillybabies.org/What_is_IMH/imh_definition.pdf).