SOCIAL AND EMOTIONAL WELL-BEING: THE FOUNDATION FOR SCHOOL READINESS

WestEd Center for Prevention and Early Intervention
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One caring, committed and conscientious leader can develop a multitude of relationships with the end result being an unlimited number of young children who are socially and emotionally ready to take on the tasks and the joys of learning about themselves and the world around them.
“Getting children ready to succeed in school begins at birth.”
Executive Summary

The past 20 years has provided a solid research base indicating the importance of the first few years of life. It is during this time that children will grow and develop the foundational skills they need to be successful in school and in their lives. Children who enter kindergarten without the skills necessary to learn often lag behind their peers. Fortunately, early intervention and supports can help close the gap before it starts to widen.¹

It is during infancy that a child develops the cognitive, physical, language, social, and emotional skills that are key to school readiness. "Striking disparities in what children know and can do are evident well before they enter kindergarten, and these differences are predictive of later school achievement. Getting children ready to succeed in school begins at birth."²

Social and emotional development refers to children’s capacity to "experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment all within the context of family, community, and cultural expectations."³ Put simply, social and emotional development is the foundation of how children learn and this development begins in infancy. Infants and toddlers, like adults, can develop psychiatric disorders, which impact their ability to achieve social and emotional wellness.

"Infant mental health," once a misnomer to mental health practitioners and clinicians, early interventionists, and early care and education providers has, during the past decade, evolved as a critical field of study and practice in California and throughout the nation. Using early brain development as its research base, pioneers in the field have shaped the way we look at early relationships and their impact on children in a variety of developmental areas.

In California, this work has evolved from the Infant Mental Health Workgroup Recommendations in 1996 to the Infant Mental Health Development Project to the Infant-Family Mental Health Initiative and to the Infant, Preschool and Family Mental Health Initiative in 2004. Although the work continues to expand, the message remains consistent: focusing on early relationships between young children and their caregivers has lifelong implications for achieving healthy social and emotional well-being. We now know that just as healthy and nutritious food is critical to a child’s physical development, what a child is fed emotionally is equally critical and may have lifelong implications.

And while diagnoses and interventions are the responsibility of mental health specialists, professionals in the early childhood, early intervention, and school readiness fields need to be able to address typical developmental concerns and how they relate to social emotional well-being.

The work described here is evolutionary as opposed to static and should be viewed as such. At each stage, we delved deeper into the

Social and emotional development is the foundation of how children learn and this development begins in infancy.
research on childhood trauma; the service systems or lack of service systems and supports available to address early social and emotional challenges; the need for trained and competent service providers; and the absence of screening, assessment, and diagnostic tools. Key findings, changes in services and systems, model and product development, and other outcomes identified at each stage of the work became a source for parallel statewide initiatives, including School Readiness and more recently, the Special Needs Project, both of which are under the leadership of the First 5 California Children and Families Commission.

Many terms are used to represent the work and the population it impacts: infant mental health; early childhood mental health; infant–family mental health; birth–3; preschool; and others. Whichever term may be used at each juncture, the core of this work is helping children and families achieve social and emotional well-being.
**Early Childhood Mental Health**

All human beings enter this world equipped with the capacity to love, learn, and grow into healthy individuals. Infants’ very lives depend on their ability to communicate their physical needs to their caregivers. We know that how and what a caregiver provides to satisfy those physical needs can have lifelong implications for children’s physical health. Are they fed nutritious foods? Are precautions taken to prevent them from life threatening illnesses? Do they receive appropriate care when they are sick?

Decades of research have provided answers to these questions feeding our understanding of the importance of appropriate physical health care for infants and young children.

Just as physical health is the condition of one’s body, mental health is the condition of a person’s state of mind and emotional life. The state of that condition can be good or poor depending on what has been fed into your body and your mind or the trauma you’ve sustained.

Today we know that infants need their physical and emotional needs met in order to grow and develop. From the moment they are born they seek to satisfy their need to be connected to other human beings. We have learned it is these fundamental relationships that are the context in which they develop a sense of themselves in relation to the world.

What happens in these relationships and the messages infants receive about themselves is the source of their social and emotional health. Are people caring and consistent? Is the world a safe and stable place? Are people attuned to the infant’s unique needs? Recent research has confirmed that the optimum development of an infant’s social and emotional health hinges on the responses of and relationships with their caregivers. This framework views difficulties expressed by young children or their caregivers as relationship difficulties; services, therefore, focus on the relationship as the unit of change, as opposed to trying to repair the child or caregiver’s behavior. Furthermore, children with developmental delays or disabilities are at increased risk for social and emotional difficulties because in addition to
the typical demands of growing up, they have the added challenges that may accompany their developmental issues, i.e., developing a sense of mastery or a sense of belonging.4

During the last decade, professionals in California and throughout the country have worked to clarify the knowledge, skills, and competencies needed to provide effective early childhood mental health services. Recognizing the impact of this emerging work on numerous fields such as foster care and other social service systems, early care and education, and children with disabilities and other special needs, as well as its implications for school readiness, state leaders, policy experts and advocates in the field embarked on a journey to assist the state and local communities to develop a system of services and supports to implement research-based best practices about relationship-based services and social and emotional well-being for young children and their families.

Recent research has confirmed that the optimum development of an infant’s social and emotional health hinges on the responses of and relationships with their caregivers.

The Early Foundation of Learning—Developing an Emotional Infrastructure

All human beings must learn how to understand and regulate their emotions to function in their families, their communities, and the world. Consequently, it is critical for young children to develop a sound emotional infrastructure in order for them to build solid relationships with their peers and teachers. This is the foundation for their future development as a student and a person and the key to their social and emotional readiness for school.

It is through the experience of having a caregiver who is emotionally available and who can provide guidance and nurturing support that the young child learns how to regulate emotions and behavior when confronted by age appropriate demands and disappointments.

Social and emotional readiness and learning does not come easily for some children. There are a variety of environmental stressors that undermine social and emotional readiness. This can lead to difficulties in attention, persistence, concentration, and impulse control. Environmental stressors include:

- Low birth weight
- Under-nutrition
- Family separations and loss
- Domestic discord and violence
- Childhood trauma, abuse and/or neglect

Children with these special circumstances are at exceptionally high risk of physical, emotional, and developmental delays.5 Furthermore, premature birth; genetic conditions, such as Down syndrome; and physical disabilities, such as hearing impairments or cerebral palsy, pose significant developmental challenges for young children. Fortunately, early intervention is effective in helping children overcome these challenges.

A recent policy paper released by Zero to Three, a national non-profit organization that promotes the healthy development of infants and toddlers, states that if “children do not achieve early social and emotional milestones, they will not do well in the early school years and are at higher risk for school problems and juvenile delinquency later in life.”6

Their paper makes strong recommendations that point out the need for services that
promote infant mental health and assure earlier identification and intervention of mental health disorders in infants and toddlers.

**Early Childhood Mental Health and School Readiness**

As the field of early childhood mental health began to take shape, state and local leaders began to examine how the practice of relationship-based services could be designed and implemented locally. Pioneers of this work were met with numerous challenges, including how to promote infant mental health as a system of services for children and families that is rooted in social and emotional well-being as opposed to pathology, to systems change issues that addressed screening, assessment, funding, and treatment for young children and families.

And as the work evolved, so too did other statewide initiatives that focused on children’s well-being. Two of these are School Readiness and the Special Needs Project, both under the direction of the First 5 California Children and Families Commission.

**First 5 California School Readiness Initiative**

School readiness refers to a child’s ability to attend to the complex tasks of learning. It is much more than having pencils and paper and knowing their ABC’s. The child who is “ready” to learn can:

- sit still,
- focus when distracted,
- concentrate when worried, and
- persist when discouraged.

Many factors go into a child’s ability to master this skill set. However, school readiness is more than just the child’s ability to develop the necessary skills and behaviors needed to be successful in school. School readiness also addresses the environments in which children spend their time.

Recent national research states that there is consensus about the key dimensions on which we can measure and address a child’s readiness for school. These five distinct dimensions are:

- Physical Well-Being and Motor Development
- Social and Emotional Development
- Approaches to Learning
- Language Development
- Cognition and General Knowledge

While each of these dimensions is separate, they are interrelated and “underdevelopment in one will negatively impact the others.” All of these dimensions are critical for the young child to learn. However, in 2000, the National Research Council and Institute of Medicine released *From Neurons to Neighborhoods*, which states that healthy social emotional development is strongly linked to success in elementary school. They emphasize this by saying that social and emotional development is just as important as literacy, language, and number skills in helping children be ready for school.

Further support for this concept comes from the National Governors’ Association Task Force on School Readiness. In their final report they note, “Children learn best when they are able to cope with their emotions, control their impulses, when they can relate with and cooperate with their peers, and when they can trust and respond to the adults responsible for their care.” Put simply, social and emotional development forms the basis of children’s knowledge of “how to learn.”
In California, the School Readiness Initiative was launched in 2001 by First 5 California with the goal of designing a coordinated, research-based approach to early care and education. The Initiative adopted the National Education Goals Panel definition of School Readiness being a three-way street:
1. Children ready for school
2. Schools ready for children
3. Communities ready with services and supports that contribute to school success

For infants and young children, the cognitive, language, physical, social, and emotional aspects of early learning and development are intertwined. And because babies and young children learn about themselves and the world by interacting with the adults who care for them, the quality of their relationships with their family and caregivers is extremely important. For these reasons, First 5 California adopted the following five essential and coordinated elements to achieving School Readiness:
1. Early care and education.
2. Support for parents and families as key providers and teachers for their children.
3. Health and social services as fundamental to children’s healthy physical, social, and emotional development.
4. Schools’ capacity to be partners with families and effective educators for their entering students.
5. Infrastructure, administration, and evaluation that support all the school readiness partners working together and getting good results.

For more information on the 5 Essential Elements of School Readiness visit www.ccfc.ca.gov/SchoolReady1.htm.

First 5 California Special Needs Project

In 2003, First 5 California funded the Special Needs Project (SNP), which is designed to support children with disabilities and other special needs and includes social and emotional development. The goal of SNP is to promote strategies that improve early identification of children with disabilities and other special needs as well as to promote school readiness for this population. To reach these goals, SNP is addressing the disparity of services between children with disabilities and typically developing children; young children who are at risk of social, emotional, and behavioral disorders but do not have a mental health diagnosis; and the availability of inclusive options in early childhood programs such as Head Start and early care and education settings.
Basic Foundations and Guiding Principles of Early Childhood Mental Health

Infant mental health refers to the broad continuum of the social and emotional well-being of infants and toddlers. It also refers to the behaviors and interactions that influence and support it. This includes family functioning and the infant-parent relationship. Consequently, a wide array of intervention needs exist from the promotion of best parenting practices to the guidance and development of parenting skills, and finally to the critical interventions for severely dysfunctional relationships between infants or young children and their families.

The basic foundations of early mental health include:
- Infant-parent family relationship and positive interactions
- Caregiver capacity to read and respond to infant cues
- Infant capacity to initiate and respond to caregiver interactions
- Availability of social supports
- Parental capacity to use social supports

These foundations can be affected by vulnerabilities within the family environment, such as poverty, biological and health factors, substance abuse, and domestic discord and community violence.

Infant and early childhood mental health, as a system, refers to the provision of supports and services that address the development of social and emotional well-being, risk conditions, and disorders in social and emotional development. The field of infant and early childhood mental health recognizes the importance that social and emotional functioning has on the health

Guiding Principles of Early Childhood Mental Health

1. Human infants are born with an extraordinary capacity to connect with other human beings. In addition they have a host of innate behaviors that help them understand and regulate their interactions. From the very beginning, infants require consistency, stability, predictability, availability, and attuned love.

2. The period of life from birth to 3 is a sensitive period of development for the formation of character or personality. The greatest period of brain development occurs from the last trimester of pregnancy throughout the first 18 months of life. During this period, nutritional, physical, social, and emotional satisfactions and failures will actually change the physical and chemical structures in the brain.

3. Pregnancy and childbirth are powerful conscious and unconscious reminders in the parent of childhood issues that can help or hinder the parent in responding to, caring for, and loving the infant. Pregnancy, birth, and the first two years of maternal care require the availability of psychological resources and emotional support. Parenting is a relationship.

4. Delivery systems must provide time for intensive and rigorous staff training and ongoing reflective supervision for those who work with infants and their parents.

5. The nature of the infant-parent relationship is best understood within the setting of the family home because it is the context of family events such as eating, sleeping, relating, and nurturing.

6. The infant-parent relationship emerges within a unique set of cultural and economic factors that provide a historical and practical context to the family and to the intervention.
The lessons infants learn from early interactions and relationships form the basic building blocks for learning later in life.

...and development of children. Research has identified this kind of development as critical.

To make a difference in the lives of young children and their families, social and emotional disorders, delays, and risk conditions should be identified and appropriate interventions should be designed and implemented. To be most effective, developmental, family support, and/or mental health services to infants and young children and their families should be provided through a culturally appropriate integrated interagency approach.¹¹

**Early Childhood Mental Health and School Readiness**

From birth, children are learning important information about their environment and their abilities. They are constantly making connections between their behavior and the response from their environment. If they reach out for comfort, is someone there or are they ignored? If they reach out in curiosity, are they rewarded or punished? If they need help with a simple task, does someone notice and assist in the successful completion or are they left to be frustrated?

If infants receive positive feedback for their initial attempts to explore and understand their environment, they learn they have someone to rely upon and become eager to try new things—they learn to persist knowing that they can be successful. The lessons infants learn from these early interactions and relationships form the basic building blocks for learning later in life.

In order for children to be successful they need a basic foundation. We once thought this foundation came from learning the ABC’s. We now know that the feelings of young children are as important as what they think.

We know that when children show up at kindergarten they are expected to be ready to learn, to sit still and focus, to express their own feelings and to get along with others. These tasks have less to do with their ability to recite the alphabet than they do with their ability to negotiate their emotions and relationships. Children who can manage their feelings and who have a repertoire of behaviors that help them cope with new and frustrating situations will be able to attend to the important work of exploring and learning. However, children who are overwhelmed with their emotions and their environment cannot attend to the everyday demands of the classroom.¹² And again, children with developmental delays or disabilities may face additional hurdles that hinder the mastery of these tasks.

Oftentimes, children who can’t sit still and have difficulty in relationships with teachers and their peers are labeled by their behavior. But children don’t behave badly just to “get attention.” There is always a reason behind their behavior and a reason why, given the vast array of alternatives, they choose one particular approach. It is the meaning behind the behavior and the reason that children act out in the way that they do that is the key to understanding the child and their family and helping them develop new ways of interacting. Children may
be acting out because of fears and anxieties that are heightened by separation and new surroundings. Some children without strong and secure attachments may have learned inappropriate ways of getting their need for love and attention met. It is often the case that the way they have learned to get their emotional and social needs met within their relationships at home, are not appropriate for the child care or classroom setting.

It becomes clear that early relationships and the interactions between caregivers, infants, and young children establish lifelong patterns that impact the ability of young children to attend to the important tasks associated with learning.

**Ghosts in the Nursery: The Beginning of the Parent-Child Relationship**

Before their child is even born, parents have begun forming the caregiver-child relationship, which is based on their own experiences. How parents respond to their infants is often influenced by their own personal histories. Parents can and do have unique interpretations and reactions to their children’s behaviors that are rooted in their own early childhood experiences and driven by their own emotional needs. For instance, a parent whose early life included abuse and neglect might bring to the parent-child relationship ill-conceived notions about rejection. In this case, when a child doesn’t want to nurse or be held for a variety of different reasons, the parent may interpret that as rejection and begin to pull away from their child as a way to cope. Selma Fraiberg, a pioneer in the field of infant mental health, termed this phenomenon "ghosts in the nursery," explaining that when parents bring their own harsh experiences into the relationship with their infant, they are unwittingly using what happened in their past to predict the future relationship with their baby.

Fraiberg began to understand the complex dance between infant and parent in her work with children who were born blind. She came to understand that how a parent interpreted and then reacted to the responses of their babies dramatically impacted how the baby reacted in turn. If, for example, the baby could not see the mother smiling down lovingly and therefore did not smile back, the mother would feel rejected and subtly begin to disconnect from the child.

But Fraiberg also learned that parents who developed an
understanding of their reactions and learned new ways of reading their babies cues, could connect and communicate despite the inability of the child to see. These parents learned that their babies were not, in fact, rejecting them—they were simply unable to provide the typical cues parents come to rely on to let them know their baby accepts and appreciates them.

All of this information is a powerful reminder of the importance of the relationship between infants and their caregivers. Seemingly unimportant interactions can and do influence an infant’s understanding of the world and their importance.

We also know that what infants learn in these early relationships informs many other aspects of their development. In fact “development in all other areas—cognition, communication, and motor skills—is organized by the emotional development of the child.”

Brain Development and Early Childhood and Infant Experiences

Information gathered through recent research has provided us with a new understanding of the way in which our brains develop. We know that we are born with millions of neurons. After birth we rapidly develop the connections between these neurons—these “pathways” make up the “wiring” for the brain and allow various parts of our brain to communicate with each other. This provides us with the ability to complete complex functions including walking, talking, and reading. Research has also revealed that “children will undergo the most rapid brain develop in the first few years of life.”

Understanding this as a critical time in the development of the brain has altered the way in which medical professionals work with children. For example, doctors now intervene earlier with vision and hearing impairments knowing that the information they receive from these senses even in infancy will have a dramatic impact on their future development.

Professionals who work with disadvantaged children have also adopted this early intervention approach. They have known for some time that children who have inadequate interaction and a lack of stimulation with their caregivers due to conditions related to poverty and other environmental factors are at increased risk for cognitive challenges. But now, research has confirmed that early intensive intervention can dramatically improve outcomes for children who initially had poor skills and prognosis.

Lack of stimulation is not the only thing that impacts the developing brain. Early trauma can have lasting effects as well. In fact, most of our understanding of the impact of trauma or chronically stressful environments on the normal development of the brain comes from our work with children who developed post-traumatic stress disorder. Research with these children suggests that they may suffer from long-term cognitive and emotional difficulties. Trauma can result from a variety of circumstances and environmental conditions. Children and infants can be seriously affected by events that impact their parents and as a result, impair their ability to engage in healthy interactions with their children. For instance we know that mothers who are depressed may not have the emotional resources to adequately nurture their
child. Similarly, parents with drug and alcohol addictions are often incapable of social and emotional interactions with their infant. Both sets of circumstances seriously limit the parents’ ability to provide consistent and responsive care. If these situations were to continue without relationship-based interventions aimed at the child and caregiver, both may remain socially isolated and emotionally traumatized.

This information supports what many child development specialists believe — that early experiences can and do play a critical role in the development of the brain. This has fueled a movement to understand the optimum environment for healthy brain development and to implement practices and approaches that support this process for infants and young children.

Brain research has given us a powerful insight into the important role experience has in brain development. For each of us, how our brains function is a direct reflection of our experiences. Experiences matter because they change the way our brains work. The brain continues to change throughout life although the majority of change takes place in the first years of life. At birth, the remarkable potential of the brain remains unexpressed. It is the experiences of childhood that express that potential. The primary senses—touch, taste, sight, smell, sound and movement—play a major role in providing the repetitive sensory stimulation and experiences that help organize the child’s developing brain. The lack of a specific sensory input during development results in abnormal development of the brain. Conversely, the more your brain is “activated” by a pattern of interaction, the more your brain will change and develop. This concept is the basis for development, memory, and learning and illustrates the important role of positive, harmonious, responsive, and predictable interactions between infants, young children, and their caregivers.

**Responsive Relationships and Early Childhood Mental Health**

There is strong biological evidence that shows that responsive caregivers and connections are critical to the ongoing healthy social and emotional development of a young child. We know that at birth infants do not have the ability to regulate their emotions and depend on their caregivers to comfort and calm them. We also know that when a caregiver does this, "the baby develops the neurological and emotional foundations that allow her to gradually learn how to regulate her emotions on her own." This ability is fundamental to all future development and learning.

When infants and young children learn that they can rely on their caregivers to provide consistent love and care, they develop a special and enduring form of an emotional relationship often called attachment. Through the attached relationship the infant and young child easily receives comfort and pleasure and finds security and safety. In an attached relationship, loss, or the threat of loss, of the specific person evokes distress. Attached relationships provide the optimum environment for the social and emotional development of a child.

Sometimes developing this relationship is challenging. Some infants and young children have a hard time expressing their needs and otherwise loving caregivers can miss important cues. These miscommunications can make the development of this special bond more challenging. This is especially true of children with special needs. They can be born with
Through positive interactions, the infant acquires:

- Pleasurable feelings about self and others
- The capacity to relate to others, shown through engagement and responsiveness
- A range, intensity, and appropriateness of affective expression
- Feelings of value and self-worth
- A sense of having an impact on one’s world
- A sense of belonging to family and community

limitations on their ability to communicate effectively, preventing otherwise loving caregivers from appropriately responding to their needs and interrupting the development of their relationship. For example, many babies with vision problems do not make good eye contact, which is one of the most powerful forms of non-verbal communication that parents and infants share.

But human interactions involve more than just one person expressing their needs with the other responding. Both parties, parent and child, have needs in a relationship. Infants and children need to be cared for and at some level parents need to feel fulfilled and rewarded for their caregiving. Oftentimes this is just a smile from the infant, or a glance or a hug. In some unique circumstances, although the parent is loving and attentive, the child does not have the physical or mental capacity to show them how much they appreciate and love their caregiver. These situations are particularly difficult for parents and they may be inclined to pull away from their baby. However, with support and guidance, these parents can learn to understand how much their baby loves and relies on them and the relationship can forge new paths of communicating and caring.

If caregivers do not provide appropriate and responsive care, children can and do receive a variety of negative messages that impact their social and emotional development. For example, if an infant’s cries for attention go unnoticed, or if they are treated poorly, they learn to be cautious and distrusting of others. Or worse, they learn that they are unworthy of caring attention from adults. Once a child develops this set of beliefs, it can rule the way they interpret all other human interactions in the future.

The parent-child relationship can have a dramatic impact on how a child will ultimately react and relate in the world. When the child enters school, the lessons they learned as an infant and a young child will be reflected in their ability to get along with and work with others.
Helping parents understand the impact of their relationship and assisting them in navigating challenging circumstances so that they can maintain an optimum environment for their child to grow and develop is an essential component of infant mental health. Today we have begun to identify services and supports that can assist all types of families in learning about the importance of early relationships and how they impact later experiences, including how they prepare for learning. In addition, we have developed tools and techniques that are aimed at empowering parents and caregivers to create nurturing environments and loving relationships.

"Out of My Head"©: A Personal History Bag© is a detailed case history described by Emma Girard, Psy.D., Senior Clinical Psychologist at Riverside County Department of Mental Health’s Preschool 0-5 Program. She tells the story of a particular intervention with a 4-year-old boy in his seventh foster placement exhibiting extreme behavior difficulties as a result of the trauma and abuse that he experienced when he was living with his birth parents.

The boy was identified and referred for evaluation at his preschool from screening concerns found in the Devereux Early Childhood Assessment administered as part of a collaborative screening project through the Public Health Department and the Riverside Preschool 0-5 Program.

After assessment and initial interventions, including play therapy with the boy and his family, a trusting relationship was developed with the therapist. At this point the focus of treatment became the boy’s symptoms of Post Traumatic Stress Syndrome. The “Out of My Head” intervention was developed as a unique and age appropriate way for the boy to deal with his trauma.

The intervention idea of a personal “History Bag” is a concrete tangible object made together by the boy, his foster mother, and the therapist. Once the bag is created the child is encouraged to draw pictures of his memories. Then the child is asked to describe his memories as the caretaker writes verbatim what the child says on the picture. The child then places the picture in the History Bag. The child’s actions of placing the memories via their drawing transforms the event they had no control of into a memory they can physically contain in their personal history bag, taking the memory “out of my head” as described by the boy in this intervention.

For more information about “Out of My Head,” visit www.wested.org/cpei/girardcasestudy.pdf.
At birth, the remarkable potential of the brain remains unexpressed. It is the experiences of childhood that express that potential.
In addition, the workgroup defined the service continuum of infant mental health as follows:

**Promotion:** Services in this category recognize the importance of early relationships on brain development, learning, and the emotional, social well-being of all young children. These services include a focus on positive parent-child and primary caregiver relationships within the home, child development setting, and other service settings for young children and their families. Promoting early mental health includes training and education that provides information about social and emotional development, including behavioral strategies to support the development of a child’s social skills, self-confidence, and ability to acknowledge feelings and express emotions appropriately.

**Preventive Intervention:** Services in this category work to reduce the effects of risk and stress and address potential early relationship challenges that have an impact on early development. Intervention strategies are designed to nurture mutually satisfying parent-child relationships and prevent further difficulties. Major child and family stressors may require the delivery of preventive intervention services in a variety of settings. Preventive intervention practices include parenting classes, home visiting services, support groups, and community and social services that are designed to strengthen family relationships and prevent more extensive treatment.

**Treatment:** Services in this category target children in distress or with clear symptoms indicating a mental health disorder. They
address attachment and relationship problems and the interplay between the child, parent, and other significant caregivers that jeopardize early mental health and emotional and social development. Specialized early mental health treatment services focus on the parent–child dyad and are designed to improve child and family functioning and the mental health of the child, parents, and other primary caregivers. Treatment strategies include child care consultation, evidence–based interventions, dyad therapy, family therapy, and specialized clinical treatment plans that focus on improving relationships that support the child’s healthy social and emotional development.

**Infant Mental Health Development Project**

Acting on the recommendations of the Infant Mental Health Workgroup, the Department of Developmental Services, lead agency in California for early intervention services for the birth–3 population with or at risk of developmental delay or disability, funded the Infant Mental Health Development Project (IMHDP) through the WestEd Center for Prevention and Early Intervention (CPEI).

IMHDP promoted awareness of infant mental health concepts and relationship-based approaches to services through statewide trainings and facilitated the development of interagency, multidisciplinary demonstration projects to implement concepts and services in several local communities. At the final statewide meeting of IMHDP, impact evaluation outcomes indicated that the project was highly successful in promoting awareness and broadening interest in infant mental health, but sustained implementation would require new funding and continued training and support.

**Infant-Family Mental Health Initiative**

Recognizing the impact of the work of IMHDP and in response to requests for increased coordination with mental health agencies and professionals, the California Department of Mental Health (DMH) funded the Infant–Family Mental Health Initiative (IFMHI) and provided coordination for the Initiative through WestEd CPEI.

The goal of IFMHI was to build county mental health system capacity to provide mental health services to infants, age birth to 3 and their families, and to implement infant–family mental health concepts and relationship-based approaches to services.

IFMHI successfully pioneered collaborative development and implementation of mental health services for children under the age of 3 and their families in California. With guidance and support from the Initiative, the four IFMHI county teams from Alameda, Fresno, Los Angeles, and Sacramento developed and implemented unique plans for collaborative training, service delivery, model development, and a clinical research and evaluation study.

The accomplishments and ongoing activities of the Initiative follow:

**Goal 1: Identification**—Identify early childhood/infant–family mental health needs, resources and services.
Goal 2: Capacity Building—Increase the number and availability of mental health specialists and other professionals able to provide infant–family and early childhood mental health services in a variety of clinical, community, and home settings.

Goal 3: Collaboration—Facilitate interdisciplinary and interagency collaboration for services and staff training.

Goal 4: Model Development—Develop replicable strategies for ongoing training, service delivery, and funding of infant–family mental health concepts and approaches to services.

Goal 5: Feasibility Study—Demonstrate the feasibility of providing clinical services to children ages 0 to 3 and their families.

IFMHI successfully established county-level teams and provided state and local support, training, and technical assistance to enhance the availability and delivery of infant–family mental health services. The four counties developed and implemented individual approaches to system development capitalizing on local resources, services, and expertise. Each county gained diverse experience in models for system development, service delivery, training, and collaboration. Their combined experience provides a foundation of information and resources in the development of an integrated, collaborative whole system of care for infants and toddlers and their families.

The statewide and local accomplishments in infant–family mental health development and the plans for expanded system development and service delivery have provided a substantial contribution to the resources, knowledge, and expertise in the field of infant mental health.  

Infant, Preschool and Family Mental Health Initiative (IPFMHI)

With funding from the California First 5 Children and Families Commission, through DMH and coordinated by WestEd CPEI, IFMHI added four new county mental health teams to its base—Humboldt, Riverside, San Francisco, and Stanislaus—bringing to eight the number of statewide counties receiving training, technical assistance, and support for interagency and interdisciplinary team work focused on early childhood mental health. In addition, the 3–5-year-old population was added as a critical focus of the work as evidenced by the School Readiness Initiative locally and other national efforts focusing on children being ready to enter kindergarten.

The accomplishments of IPFMHI were:

1. Initiation or expansion of mental health services for children 0–5 and their families in the eight pilot counties.

2. Development of infrastructure, screening and assessment, and billing and funding sources to support the provision of mental health services to children 0–5 and their families.

3. The expansion of local community awareness, understanding, and knowledge of infant and preschool mental health, and of relationship–based services through interagency and interdisciplinary trainings.

4. The expansion of mental health provider capacity to serve children 0–5 and their families through training, consultation, and supervision of mental health clinicians and development of competencies to define the training needed to provide infant–family and early mental health services.

5. Expanded and strengthened interagency collaboration.

See www.wested.org/cpei/ifmhfifinalreportp hasei.pdf for the complete IFMHI Final Report.
Successful evaluation efforts with positive outcomes shown for the children and families served as documented in the Clinical Services Study, for participants in training shown by the training evaluations and participant profiles, and for all participants in the Initiative as documented in the Impact Evaluation.

IPFMHI’s long-term goal and the core of its work was the development of state, county, and local capacity to serve young children and their families through a statewide network of coordinated relationship-based mental health services.

The Clinical Services Study

The Clinical Services Study (CSS), a component of IPFMHI, was a quality improvement study developed to evaluate the effectiveness of mental health treatment services for children ages birth to 5 and their families. Screening and demographic data was collected from 388 families at intake. Detailed assessment data was collected at intake and later in treatment (after an average of 22 sessions) for 93 families receiving relationship-based mental health treatment services from mental health provider agencies providing services for public mental health departments in the eight counties participating in IPFMHI. The common set of measures and tools used to screen, assess, and gather data from the families included mental health diagnosis, development, the parent-child relationship, parental stress, and resources and supports.

Results of the study showed no group differences between the 93 children and the 388 children indicating that the children and families in the study were similar to other children and families served by public mental health. Analysis of outcomes from the measures showed statistically significant improvement in the well-being of the families served by agencies and providers through the study.

Developmental risk factors declined from 53% to 40% and at-risk scores on the Ages and Stages Questionnaire (ASQ) for cognitive functioning declined from 38% to 13%. The percent of parents reporting overall parenting stress in the clinically significant range on the parenting stress measure dropped from 51% to 42%. The positive outcomes show that relationship-based interventions for very young children reduced symptoms of mental disorder; accelerated child development; improved the parent-child relationship, resources, and supports; and reduced parental stress. The Executive Summary of the CSS report, including an evaluation of the measures, is available at www.wested.org/cpei/familyresource/cssexecsumm.pdf.

Building Capacity

IPFMHI addressed the shortage of professionals and paraprofessionals trained to evaluate and intervene with early social emotional and behavioral needs for children 0-5 through the development of training and technical assistance plans for each county based on their specific strengths, resources, and needs. All plans provided education and training for interdisciplinary providers and training for mental health specialists. State-level activities included technical assistance, presentations, and trainings in collaboration with other state and national agencies as well as cross-county training and resource sharing facilitated by the state Initiative team. The common framework of training that was supported by IPFMHI and carried out by the counties with a diversity of approaches included topical trainings, ongoing reflective supervision, case consultation, local meetings and committees, and Statewide IPFMHI All County Meetings. For more information about the framework and a complete description of each county’s approach to capacity building see the Building Capacity Report at www.wested.org/cpei/familyresource/buildingcapacity.pdf.
Training and Personnel Competencies

Training Guidelines and Recommended Personnel Competencies: Delivering Infant-Family & Early Mental Health Services is another report developed by IPFMHI that recommends a framework for training. It describes two sets of guidelines for training service providers. One set is focused on developing applications of the core concepts of practice for mental health practitioners. The other set of guidelines introduces early mental health concepts and general principles of practice to core providers. (Core providers are professionals working with infants, toddlers, and preschoolers and their families from the fields of child care, early childhood education, early intervention, nursing, occupational therapy, physical therapy, speech and language pathology, special education, and human development.)

These guidelines provide a concise resource developed by infant-family and early mental health experts containing recommendations for the provision of training and personnel competencies necessary for effective delivery of infant-family and early mental health services. They reflect the framework and content of the trainings provided by the Initiative. For the complete report visit www.wested.org/cpei/familyresource/personnelcomp.pdf.

Evaluation

Evaluation was one of the major goals of the Initiative and provided the impetus for developing tools and procedures for both ongoing and overall evaluation of activities and outcomes. Ongoing evaluation and data collection served to document accomplishments and track changes and provided a bank of information to determine the immediate and longer-term impact of the varied Initiative activities on individuals, agencies, and communities. The following tools were initially developed for this purpose:

- A Participant Profile to identify the experience, attitudes, knowledge, and skills of IPFMHI participants. The profiles were also used to collect information on providers and agencies with training and experience in infant-family and early mental health concepts, practices, and intervention and treatment services for children younger than 5 years of age and their families.
- The Training/Activity Evaluation Form to evaluate the training, consultation, or technical assistance provided in counties and at the state levels. A standard form was developed and adapted for use in various activities to assess how well the training accomplished its goals and its relevance to the participant’s daily work.
- The IPFMHI Impact Survey, a web-based survey, was developed and connected to the information obtained in the Participant Profiles. Participants who provided e-mail addresses were contacted in the last month of the Initiative and asked to complete this online survey, which provided both quantitative and qualitative data on the impact of the Initiative on individuals, agencies, and communities. Findings from all three evaluation and documentation sources suggest that

- The Initiative was successful in targeting mental health professionals and agencies for training and technical assistance while maintaining a focus on interagency and interdisciplinary collaboration.
- Ongoing training, consultation, and reflective supervision continue to be needed to build professional skills and expertise in this emerging field.
- Information and technical assistance
is needed to identify new resources and strategies for effective billing and funding of services, training activities, and reflective supervision for mental health and other early intervention, childhood development, and family support professionals. Impact & Evaluation Findings, available at www.wested.org/cpei/familyresource/impacteval.pdf, provides an overview of findings from the Initiative’s Participant Profiles, Training/Activity Evaluation Form and Impact Survey.

In the end, the success of the effort is all about the relationships that are developed, between:

- Departments within agencies
- Departments across agencies
- Agencies and families
- Families and the community
- Caregivers and families
- Children and caregivers
- And most important of all between parent and child.

Phase 1 of IPFMHI ended in June of 2003. The second phase was funded to complete the work begun in Phase 1, including continued delivery of services in the eight pilot counties, development of products based on the work of IPFMHI, and the provision of technical assistance and support to school readiness programs. To learn more about the eight county models and how they implemented collaborative delivery of relationship-based interventions see The IPFMHI Phase II Final Report: Consolidation and Sustainability: The Status of Infant Family and Early Mental Health Services in IPFMHI Pilot Counties at www.wested.org/cpei/familyresource/phaseIIfinalreport.pdf.

Additionally, as the first phase of IPFMHI was coming to a close, First 5 California was launching the Special Needs Project to work with families, caregivers, child care providers, and social services providers to support young children with a broad range of special needs in the context of and as an integral part of the First 5 School Readiness Initiative. The Special Needs Project addressed two specific areas—children with disabilities and other special needs and early childhood mental health. First 5 determined that merging these two areas would be beneficial to maximize early identification, improve connections to services, and provide services and supports to children in need.

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Key findings of the Infant, Preschool & Family Mental Health Initiative

- Primary relationships have a significant impact on child development.
- Effective relationships with families and service providers are critical to achieving positive outcomes.
- Infant, preschool, and family mental health services can be provided through state and local mental health agencies.
- Interagency, interdisciplinary and community collaboration are needed to expand service delivery.
- Team support and supervision are essential for service providers.

The work of the Initiative is a significant contribution to the ongoing development of infant–family and early mental health services in California.
Mental health services for children aged birth to 5 and their families have changed dramatically in the past four years. Integrated collaborative delivery of relationship-based interventions is thriving in all eight pilot counties. Phase II of the Initiative successfully completed the work of Phase I and developed products and resources that will benefit developing infant and early childhood mental health programs, school readiness sites, and Special Needs Project Demonstration Sites. The experiences and accomplishments of the eight pilot counties provide unique models for integrated collaborative service delivery that address the diversity of strengths and resources within each county. The work of the Initiative is a significant contribution to the ongoing development of infant-family and early mental health services in California.

For detailed information about IPFMHI accomplishments and lessons learned, visit www.wested.org/cpei/ipfmhi_accomplishments.pdf.

**Lessons Learned**

The various phases of work in the early childhood mental health arena have produced a deep knowledge of the successes and challenges to providing relationship-based services to young children and families. Specific components have emerged as critical to successfully implementing these services and supports in local communities with parallel efforts such as school readiness.

**Evidence-Based Practices and Promising Practices**

Evidence-based practices sometimes called “best practices” or “exemplary models” are those practices, treatments, therapies, or programs that have been found through research to have consistently good outcomes. A growing increase in awareness of evidence-based practices is leading funders, policymakers, mental health professionals, and families to seek out treatments that have a solid scientific base. With this in mind, several of the IPFMHI counties sought training and adopted evidence-based practices to serve very young children and their families.

Incredible Years and Parent Child Interaction Therapy are the two forms of evidence-based practice that have been most often implemented in the IPFMHI counties. Incredible Years targets children ages 2–8 years old, their parents, and teachers with the use of three sets of developmentally appropriate curriculum. It is designed to promote emotional and social competence and reduce and treat behavioral and emotional problems in young children. Parent Child Interaction Therapy (PCIT) is aimed at children with conduct disorders, ages 2–8, and their parents. It consists of 12 sessions of parent-child therapy geared toward improving the quality of the relationship between the parent and child. Visit www.incredibleyears.com for more information.

Promising practices refer to treatment approaches that are supported by research and agreed upon by experts as to the effectiveness of the approach. Alicia Lieberman and Patricia Van Horn of the University of California, San Francisco’s Child Trauma Research Project (CTRP) at San Francisco General Hospital, a mental health provider group that participated in the IPFMHI Clinical Services Study, published *Don’t Hit My Mommy!*27, a manual for child-parent psychotherapy with young witnesses of family violence. The manual is designed to provide treatment guidelines to address the behavioral and mental health problems of infants, toddlers, and preschoolers whose relationships have been disrupted by violence. The guidelines were developed from evidence-based approaches to therapy developed and evaluated by CTRP. San Francisco County’s Infant Parent Program
and Alameda County’s Infant Mental Health Seminar are using approaches very similar to those researched at CTRP. This publication is available at www.zerotothree.org/bookstore/.

Watch, Wait and Wonder\textsuperscript{28} is a dyadic child led psychotherapeutic approach that has been empirically tested and is used with children ages birth–9 with relational, behavioral, and regulatory and developmental problems. IPFMHI sponsored trainings on this approach in Sacramento and Los Angeles Counties. Sacramento County noted use of this approach in some of its mental health provider agencies. Information about Watch, Wait, and Wonder is available at www.hincksdelcrest.org.

**Infant and Early Mental Health Consultation**

Infant and early mental health consultation refers to a reflective and instructive exchange of information between an experienced and competent mental health provider and a person or group seeking assistance or instruction in relationship-based approaches to providing services. Consultation helps providers of services to young children integrate the concepts and principles of infant mental health into their programs and helps them to identify children and families in need of more intensive mental health treatment services.

This model allows clinicians to meet with staff to discuss and review classroom management strategies that support healthy social emotional development without first enrolling a child into treatment. It neither stigmatizes the child nor blames the teacher, as is often the case when signs of early issues are allowed to develop until medically necessary criteria are met.\textsuperscript{29}

IPFMHI counties provided consultation services to early childhood education agencies, early intervention agencies, public health, social services, child protective services, child care agencies, homeless children’s shelters, and school readiness sites. The use and availability of consultation services has grown as it has been promoted and supported by grants from local First 5 Children and Families Commissions in various counties and strongly encouraged by IPFMHI and First 5 as part of school readiness programs and in preparation for work with Special Needs Project Demonstration Sites.

**Interagency Collaboration**

Collaboration is the foundation to success in the development of a system of infant–family mental health services. It requires the establishment of relationships with groups and agencies that are able to provide training resources, a broad range of providers of services for infants and families, and advisory groups with an interest in children and families. An assessment of the types of organizations with which county mental health systems have established relationships in each of these areas provides an indication of the progress counties have made in developing collaborative services and resources.\textsuperscript{30}

**Capacity Building/Training**

Training and technical assistance must be geared to the local needs of those seeking
training and information must be provided that is relevant to the population they serve. Planning training events requires adequate time and must take into consideration the constraints that providers face in getting release time from their work and support from their supervisors to undertake training. Training events that bring together presenters from outside the local area should be planned so that the presenter knows who will be in the audience and knows what the desired training is; otherwise cost and effort is expended to bring about an event that does not make the best use of the presenter or trainer’s skills and fits poorly with the audience’s needs. Staff time must be assigned to make this possible. Evaluation of each training event is important as well, and this evaluation should link the particular event to the overall training and technical assistance goals of the project. It is important to follow through after the training event by making the training materials available by copies or website, and by providing attendance and participant information to allow those who attend to build on the opportunity to link with each other to provide better services in their locality.

**Reflective Supervision**

Reflective supervision emphasizes a supportive supervisor/supervisee relationship to foster the development of insight and skills about the process and content of the clinical work with children and families. Just as dyadic
interventions in infant and early mental health require a relationship-based approach to providing services, reflective supervision is a relationship-based approach to providing supervision and staff support. It is an important component of training and ongoing support for clinicians developing skills in infant-family and early mental health as well as early interventionists and home visitors practicing relationship-based approaches to services. Unfortunately, supervision, like consultation, is not reimbursable. Therefore if it is not paid for as part of a training program or special grant, it is difficult for county programs to incorporate into their ongoing work.

Parallel Process

The concept of parallel process recognizes that modeling behaviors is unavoidable and happens not just within families but also at every level of work that involves families with young children. So, if the goal is to help parents to recognize the powerful influence that positive interaction has when they live, learn, and play with their children, then staff and service providers must be prepared and skilled in modeling positive techniques that build on inherent strengths of parents and families. It is through experiencing the same process that a parent can learn and model that behavior with their children. Parallel process becomes a template for the work of the staff and the parent; it becomes a model for the relationship and training of the staff by the supervisors in their sites and programs.

Relationship-Based Intervention

Relationship-based intervention is the simple acknowledgement that genuine efforts to understand and relate to the meaning of a child’s behavioral, cognitive, and social and emotional state is central to working with the birth-5 population. Understanding a family’s beliefs about the meaning of their child’s behaviors is a primary source to comprehending, valuing, supporting, and overcoming developmental struggles; in other words, helping the child and their family achieve positive outcomes. This approach switches the focus from a service provider “doing something to fix the child” to helping guide the parent or caregiver through the process of identifying what the child is expressing, their response to it, and how that impacts the relationship.

A relationship-based approach switches the focus from a service provider “doing something to fix the child” to helping guide the parent or caregiver through the process of identifying what the child is expressing, their response to it, and how that impacts the relationship.
Achieving Social and Emotional Well-Being and School Readiness

Indications of Emotional and Social Behavioral Concerns

Children can exhibit a variety of behaviors that may indicate they are experiencing emotional difficulties. While people often characterize children simply by their behavior, researchers and practitioners recognize that maladaptive and aggressive behaviors may be indicators of poor social and emotional functioning. As stated earlier, the actual behavior is less important than what the behavior is trying to tell us—they may be important signs of emotional distress and may warrant intervention and treatment.

Some of these signs are:

- Change in eating habits
- Change in typical behavior pattern
- Does not enjoy playing or is aggressive with others
- Unable to obey even a few simple and realistic rules
- Persistent disobedience or aggression toward the teacher
- Depression, sadness, withdrawal, or irritability
- Overly active and disorganized in daily routine
- Overly dependent or needy

A child who is struggling in his or her relationship to others, has difficulty forming relationships, is uninterested in new activities, or is habitually distressed will have a great degree of difficulty in a learning setting. “In fact, more and more young children are being expelled from child care and preschool for behavior problems and supports are not available for these children, their parents, or their caregivers. Without early identification from screening, assessment, and effective intervention these problems will escalate.”

Services and Supports for Families and Caregivers

Early childhood and infant mental health programs can provide a variety of services and supports to assist families and caregivers in developing optimum social and emotional readiness for learning. Services for infants and toddlers can:

- Promote infant mental health
- Prevent the occurrence or the escalation of mental health problems and minimize social-emotional developmental risk
- Treat by providing intensive services to address mental health needs and to support the return to positive developmental programs

This service continuum—promotion, preventive intervention, and treatment—has a set of goals and methods.

Promotion: To create caring environments that strengthen the social and emotional development of young children; to address social and emotional issues as they arise in early intervention, child care, preschool, and Healthy

More and more young children are being expelled from child care and preschool for behavior problems and supports are not available for these children, their parents or their caregivers.
Start environments and to include activities that proactively address social and emotional developmental issues.

The strategies to achieve these goals include helping caregivers and parents:

- Read and understand child behavior and feelings
- Differentiate feelings from behaviors
- Acknowledge feelings
- Encourage expression of anger, sadness, and joy
- Provide consistent, predictable rituals and routines and expectations of behavior
- Show affection to child

**Preventive Intervention:** To develop strategies and provide focused attention to build resilience in children whose social emotional development is at risk as evidenced by challenging behaviors.

The strategies to achieve this goal include helping caregivers and parents:

- Understand the child’s experience of the world
- Develop an emotional care plan
- Identify and respond to environmental and emotional triggers
- Provide individuals guidance in disagreement resolutions, routine changes, and protection from over stimulation.

**Treatment:** To identify and refer young children who would benefit from family-centered community mental health services and supports.

The strategies to achieve this goal include:

- Developing an emotional care plan with the parent
- Facilitating the development of relationships between the parents and

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**Play Therapy with Preschoolers Using the Ecosystemic Model**

Play Therapy with Preschoolers Using the Ecosystemic Model is a chapter written by Sue Ammen and Beth Limberg in the book, *Handbook of Training and Practice in Infant & Preschool Mental Health*, edited by Karen Finello and published by Jossey Bass in New York in 2005. Sue Ammen of Alliant International University in Fresno served as a consultant and trainer for the Infant, Preschool and Family Mental Health Initiative. Beth Limberg also provided training for the Initiative and is program director for the Building Blocks Program, an intensive mental health intervention program for children birth to 5 and their families at the River Oak Center for Children in Sacramento, California. They developed a composite case study to represent a mix of symptoms and concerns that is not unusual. The case study describes intervention based on the Ecosystemic Model of play therapy. This model is developmentally organized, strength-based, relationship-focused and contextually grounded in the child’s ecosystem.

According to Ammen and Limberg, “Ecosystemic Play Therapy” (EPT) can be seen as a framework for play therapy rather than a specific modality. As such many modalities are integrated into the EPT framework depending on the needs of the client and the preference and training of the therapist. In the case example, components of several distinct therapeutic approaches (including Theraplay®, Watch, Wait, & Wonder®, and social learning theory) are thoughtfully integrated in the EPT assessment and intervention.

The case example describes the EPT model of assessment and intervention for 4-year-old Germayne, an African American boy referred by his grandmother, Ms. Anderson, who is also his primary caregiver. The social worker told her to make the call because Germayne had become aggressive with his younger brother and sister and she was worried that Ms. Anderson couldn’t handle him. Germayne’s mother is in prison. His father lives with them but is frequently absent. Intake and assessment, treatment planning, the treatment process, and ending treatment are explained in detail with reference to the EPT framework.

For more information about the Ecosystemic Play Model, visit www.wested.org/cpei/limbergcasestudy.pdf.
providers of community mental health services and supports
• Referring families to services and supports that meet their needs

How School Readiness Sites Can Help
Quality early care and education, coupled with mental health goals, can increase the quality of life for infants, toddlers, and young children; result in success in the classroom, playground, and neighborhood for school-age children; and facilitate the ability to make good choices as teenagers.33

Through the work of IPFMHI, we have learned about how families and school readiness sites can work together to promote optimum infant, family, and early childhood mental health development and support future school success. We have developed a broad array of practices and approaches that can assist families, caregivers, and school readiness sites in their efforts to help young children develop social and emotional readiness for school.

Standards of Practice Essential to Mental Health Services and Quality Early Care and Education

1. Relationship Based
The promotion of stable, nurturing relations is a basic prerequisite for mental health.

Mental health services, whether they focus on child-specific concerns, general consultation, or programmatic concerns, are centered on and implemented through relationships. Relationships between teachers, program directors, families, children, and the mental health community form the basis for the provision of mental health services. Short-term interventions may be effective, however, frequently, considerable time is needed to build the relationships that support change for children, families, and programs.

Quality early care and education, coupled with mental health goals, can increase the quality of life for infants, toddlers, and young children.
2. **Engage Families and Providers at All Levels**

Of critical importance is cooperation, interactions, and collaboration among all parties involved, including full parental knowledge of, and consent for, mental health services. No one can do the job alone; everyone faces pressures and obstacles. Solutions come if there is teamwork, mutual respect, and good will. The full endorsement and support from top management staff, including adequate release time for teachers, is essential to the success of early care and education mental health services. Mental health can help teachers support the families’ primary role in their child’s development.

3. **Be Flexible**

Responsive creativity and innovation help develop solutions to respond to particular needs, cultures, and settings. Inventive solutions among families, teachers, and mental health consultants are a prerequisite for success and should be encouraged. If the solution requires a change to the established patterns and procedures, the mental health provider will work with the teacher and families to maximize the success of that innovative solution, both in the home and the classroom. The emotional wellness of children and families is the primary goal.

4. **Socioculturally Competent**

Appropriate mental health services acknowledge and address the diversity among children, teachers, families, and mental health providers. It is imperative to pay attention to diversity at all levels. Every person’s experience of the early care and education setting is unique, depending upon their cultural and social background, which spans ethnicity, culture, migration, experiences, disability, and socioeconomic status. Awareness and attention to such differences creates a context for shared concerns about the child, and supports effective and mutually beneficial relationships.

5. **Strength Based**

Strength-based services promote and affirm assets in the child, in the family, and in the early care and education program. This orientation enables families and caregivers to develop their resources and abilities to more effectively respond to a child and the child’s environment.

6. **Begin Early**

Services should focus on the promotion of mental health through prevention and early intervention. Services should stress training for teachers with a focus on early warning signs and systems to identify vulnerabilities and problem areas, as well as consultation to establish preventive interventions in the early care and education program environment. Services should be made available until the mental health issue or concern has been effectively addressed.

7. **Develop and Support a Network of Well-Trained, Competent Mental Health Service Providers**

Providers should operate based on a strong foundation of existing research and training in child development theory, early care and education practices, and early childhood mental health. The mental health service organization should have adequate resources to provide ongoing training and supervision to mental health providers with varying levels of experience.
How Programs and Staff Support Early Childhood Mental Health

It is well-established that infants and toddlers can experience a full spectrum of social-emotional functioning, ranging from mental health—an ability to form satisfying relationships with others, play, communicate, learn, and experience the range of human emotions—to disorders of very early childhood.

Staff-parent interactions, characterized by resiliency, consistency, trust, and mutual respect, offer support to the child and family. They honor the family’s language and culture, and acknowledge the central role parents play in their children’s lives. A strengths-based approach recognizes and encourages parents’ capacities and provides needed assistance in coping with difficulty.

When parents experience supportive interactions with a caring staff member, they are better able to provide this type of relationship to their children. The experience of a supportive relationship with staff helps parents to create a supportive relationship with their children. And when the parent-child relationship is stronger, more nurturing, and more flexible, children’s mental health—their ability to process their feelings, develop trust, and engage in fulfilling interactions with others—is enhanced.

The following are tools and techniques to help develop a healthy and productive parent/staff relationship.

1. **Provide parents with empathy and guidance.** Taking a moment to let a stressed parent let you know what is going on in her life, and letting you know that you recognize how challenging it can be to raise young children, can go a long way. Being willing to listen goes a long way toward helping a parent feel cared about, connected, and supported. Parents who feel supported are often calmer and more empathetic with their children.

2. **Provide parents and caregivers with the information, support, and skills that help them in their role in promoting their child’s social emotional growth.** Sharing information about how children typically behave; helping a parent recognize their child’s temperament, preferences, and interests; and showing some strategies for managing behavior can all be useful. Organizing articles, books, and videos, or setting up parent groups or parenting education sessions can also be helpful.

3. **Learn about parent’s individual and cultural values and beliefs.** This understanding can help you in supporting parents’ wishes and in allowing you to negotiate conflicts of opinion that are based on individual and cultural differences. As one example, among many families raised in the United States, young children are expected to begin feeding themselves during the second year of life. This is a valued sign of independence. In others, where food is scarce and hunger is common, parents continue to feed children up to 5 years of age, in order to avoid wasting food. Asking a parent to help you understand the beliefs and values underlying their child-rearing practices can aid you in working collaboratively with parents to support their child’s social emotional health.
4. **Identify early signs of emotional or behavioral concerns.** By listening to and taking seriously parents’ concerns about their child’s growth and behavior, by carefully observing children, and by assuring that all staff are knowledgeable about typical child development and behavior, you can be alert to early signs of developmental or mental health difficulties in very young children.

Staff are able to provide this level of support to parents because they themselves have experienced this in their relationships with programs leaders through the reflective supervision process discussed earlier.

Following are tips that program leaders can use to strengthen staff–parent relationships in their programs and promote children’s mental health.

1. Encourage staff’s feelings of confidence and competence with families by helping them to identify the strengths they bring to relationships.

2. Ask what staff are learning from their relationships with families in order to stimulate their curiosity and foster their professional growth on the job.

3. Train staff in how to talk with families about boundaries in their relationships. Clarifying boundaries and other program policies (e.g., rules of confidentiality) with parents helps to establish relationships rooted in mutual respect and openness.

4. Wonder with staff about the family’s goals—not just the child’s. Identify ways that family members can be involved in services.

5. Get to know the families in your program. Draft a list of questions that staff may use to learn more about the families with whom they work. For example, center–based staff may wish to know how many children the mother has? What are their ages? What language does the family use at home?

6. With staff, consider how the keys to effective relationships—self-awareness, careful observation, and flexible response—are an important part of their relationships with families. Discuss how these same skills help parents provide responsive care to their children.

7. Welcome families from diverse cultures. While challenging, it is critical to recruit staff who speak the home languages of the families in your program. In addition, make pertinent program information available in other languages. Often foreign language programs at universities can locate student or faculty volunteers to help with low-cost or no-cost translations.

8. Encourage parents to provide feedback on the program and its services by organizing an annual survey of what went well that year and what could work better. Report back to families what you learned from the survey and how the program will change as a result so parents know how their feedback is shaping services.

9. In training and supervision, encourage staff to see things from the parent’s perspective. Ask, “What might motivate him/her to do that?” or, “How do you suppose she was feeling then?”

10. Ask about the resources available within the extended and nuclear family, parents’ strengths, and wonder about the unique quality of the parent–child relationship. How can these be used to support the ongoing development of the family system?
Final Thoughts

In the end it is the relationships we develop that are the foundation of all components of early childhood mental health and emotional well-being and the practices and approaches that support it. The model of support, collaboration, and respect that promotes the development of community collaborations is also at the center of the relationship between the supervisor and the staff. With healthy modeling of positive reactions and caring connections between staff and parents we set the stage for the heart of the entire approach—the development of a loving and responsive relationship between parent and child.

In this model, optimum infant, family and early childhood mental health flows from the top. At the apex are the community leaders who are providing support and guidance through thoughtful and respectful communications to supervisors and staff, fostering their ability to encourage and support parents in understanding themselves, the origin of their emotions, and effective tools for managing their feelings and behavior. In turn the parent with new insights and techniques can engage the child in what will be the relationship of a lifetime and one that is the foundation of social and emotional development of their infant and young child.

In the context of this model, one caring, committed, and conscientious leader can develop a multitude of relationships with supervisors and sites and they in turn can support countless parents with the end result being an unlimited number of young children who are socially and emotionally ready to take on the tasks and the joys of learning about themselves and the world around them.
## Appendix A.

**Case Studies: Family Stories Explain Relationship-Based Approaches to Intervention**

<table>
<thead>
<tr>
<th>Case Study Title, Origin and Authors</th>
<th>Mental Health Providers</th>
<th>Approaches to Intervention</th>
<th>Summary of Key Features</th>
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| **The Brain Connection:** Armed with new research on developing brain structure, social workers can help fix troubled baby/parent relationships  
*San Francisco Chronicle November 14, 2004 by Rob Waters* | • Children’s Hospital of Oakland  
• UCSF Infant Parent Program                               | • Infant Parent Psychotherapy  
• Infant Message  
• Nurse Home Visits to Newborns                           | Several infant-parent relationship interventions are woven with a brief history of infant mental health and results of research that has prompted the growth of new programs that focus on the mental health needs of very young children and their families. |
| **Infant Parent Program/Daycare Consultants: A System of Care in Itself**  
*Georgetown Institute, System of Care Conference, June 2004  
Judy Pekarsky, Miriam Silverman, and Adriana Taranta* | • UCSF Infant Parent Program  
• UCSF Daycare Consultants                                | • Infant Parent Psychotherapy  
• Mental Health Consultation to Child Care/Preschool      | A story of continuity of care for a toddler and his adoptive mother through preschool and transition to kindergarten demonstrates collaboration, access to other services, intervention, and support for the child and family, support for preschool staff, and support for school readiness. |
| **“Out of My Head”: A Personal History Bag**  
*Georgetown Institute, System of Care Conference, Poster Presentation, June 2004  
Emma Girard, Ph.D.* | • Riverside County 0-5 Preschool Program                   | • Intervention technique for young children with Post Traumatic Stress Syndrome | A successful intervention with a severely abused and traumatized 4-year-old boy in his seventh foster placement ends in adoption. |
| **Play Therapy with Preschoolers using the Ecosystemic Model**  

**Mental Health Providers**

- Children’s Hospital of Oakland
- UCSF Infant Parent Program
- UCSF Daycare Consultants
- Riverside County 0-5 Preschool Program
- River Oak Center for Children, Building Blocks Program, Sacramento

**Approaches to Intervention**

- Infant Parent Psychotherapy
- Infant Message
- Nurse Home Visits to Newborns
- Mental Health Consultation to Child Care/Preschool
- Intervention technique for young children with Post Traumatic Stress Syndrome
- Ecosystemic Play Therapy
Appendix B.

Index of Website Links

First 5 California School Readiness Initiative

The School Readiness Initiative engages families, community members, and educators in the important work of preparing children, birth to age 5, for elementary school. This Initiative adopted the definition of school readiness developed by the National Education Goals Panel (NEGP) which covers three aspects of a child’s life: children’s readiness for school, schools’ readiness for children, family and community supports, and services that contribute to children’s readiness for school success.

The NEGP definition is the framework for the five “Essential and Coordinated Elements” required of every School Readiness program. For more information on these 5 Essential and Coordinated Elements of School Readiness visit http://www.ccfc.ca.gov/SchoolReady1.htm

The Brain Connection

“The Brain Connection” is a newspaper article written by Rob Waters for the San Francisco Chronicle on November 14, 2004. This article provides an overview of infant and early mental health in the Bay Area of California. Through interviews with clinicians and other service providers at the University of California San Francisco Infant Parent Program and Children’s Hospital and Research Center in Alameda County and other program staff serving families in Alameda County, the writer draws on family stories to explain the rationale for and examples of relationship-based interventions. For the complete story visit http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2004/11/14/CMGA99BSEII.DTL&hw=The+B

California Infant Mental Health Workgroup

In 1994, the California Infant Mental Health Workgroup defined major issues related to the promotion of social and emotional health and the importance of intervention for social-emotional delay and atypical behaviors in children from birth to 3 years of age. The workgroup developed recommended guidelines for screening, assessment and intervention services to address social and emotional health and development. For the California Infant Mental Health Workgroup Executive Summary Report, visit www.wested.org/cpei/execsumm.pdf.

Infant-Family Mental Health Initiative

The goal of the Infant-Family Mental Health Initiative (IFMHI) was to build county mental health system capacity to provide mental health services to infants and toddlers, age birth to 3, and their families and to implement infant-family mental health concepts and relationship-based approaches to services.

IFMHI successfully pioneered collaborative development and implementation of mental health services for children under the age of 3 and their families in California. With guidance and support from the Initiative, the four IFMHI county teams from Alameda, Fresno, Los Angeles, and Sacramento developed and implemented unique plans for collaborative training, service delivery, model development, and a clinical research and evaluation study.
The statewide and local accomplishments in infant–family mental health development and the plans for expanded system development and service delivery have provided a substantial contribution to the resources, knowledge, and expertise in the field of infant mental health. See www.wested.org/cpei/ifmhifinalreportphasei.pdf for the IFMHI Final Report.

The Clinical Services Study

The Clinical Services Study (CSS), a component of the Infant, Preschool & Family Mental Health Initiative (IPFMHI), was a quality improvement study developed to evaluate the effectiveness of mental health treatment services for children ages birth to 5 and their families. The complete CSS report, including an evaluation of the measures, is available at www.wested.org/cpei/familyresource/cssexecsumm.pdf.

Building Capacity

The Infant, Preschool & Family Mental Health Initiative (IPFMHI), addressed the shortage of professionals and paraprofessionals trained to evaluate and intervene with early social emotional and behavioral needs for children 0–5 through the development of training and technical assistance plans for each county based on their specific strengths, resources, and needs. For more information on the framework and a complete description of each county’s approach to capacity building see the Building Capacity Report at www.wested.org/cpei/familyresource/buildingcapacity.pdf.

Training and Personnel Competencies

Training Guidelines and Recommended Personnel Competencies: Delivering Infant–Family & Early Mental Health Services are guidelines that provide a concise resource developed by infant–family and early mental health experts containing recommendations for the provision of training and personnel competencies necessary for effective delivery of infant–family and early mental health services. They reflect the framework and content of the trainings provided by the Initiative. For the complete report visit www.wested.org/cpei/familyresource/personnelcomp.pdf.

Evaluation

Evaluation was one of the major goals of the Initiative and provided the impetus for developing tools and procedures for both ongoing and overall evaluation of activities and outcomes. Ongoing evaluation and data collection served to document accomplishments and track changes and provided a bank of information to determine the immediate and longer-term impact of the varied Initiative activities on individuals, agencies, and communities. The full report, Impact & Evaluation Findings, available at www.wested.org/cpei/familyresource/impacteval.pdf, provides an overview of findings from the Initiative’s Participant Profiles, Training/Activity Evaluation Form, and Impact Survey.

Infant, Preschool and Family Mental Health Initiative Phase II

The experiences and accomplishments of the eight pilot counties provide unique models for integrated collaborative service delivery that address the diversity of strengths and resources within each county. The work of the Initiative is a significant contribution to the ongoing development of infant–family and early mental health services in California.
To learn more about local accomplishments, the eight county models, and how counties implemented collaborative delivery of relationship-based interventions see The IPFMHI Phase II Final Report: Consolidation and Sustainability: The Status of Infant Family and Early Mental Health Services in IPFMHI Pilot Counties at www.wested.org/cpei/familyresource/phaseIIfinalreport.pdf.

**Infant, Preschool and Family Mental Health Initiative: Accomplishments and Lessons Learned**

The Infant, Preschool and Family Mental Health Initiative (IPFMHI) and the Special Needs Project are both First 5 California Children and Families Commission (CCFC) funded projects that promote optimal early childhood development and prepare children to be ready for school. This report emphasizes the lessons learned from the experiences and accomplishments of IPFMH and provides specific recommendations as to how school readiness demonstration sites might enhance, expand or create services to better meet the social and emotional needs of very young children in the community. For the complete report, visit www.wested.org/cpei/ipfmhi_accomplishments.pdf.

**Incredible Years and Parent Child Interaction Therapy**

Incredible Years targets children 2-8 years old, their parents, and teachers with the use of three sets of developmentally appropriate curriculum. It is designed to promote emotional and social competence and to prevent, reduce, and treat behavioral and emotional problems in young children. Parent Child Interaction Therapy (PCIT) is aimed at children with conduct disorders, ages 2-8, and their parents. It consists of 12 sessions of parent-child therapy geared toward improving the quality of the relationship between the parent and child.


**Don’t Hit My Mommy!**

Don’t Hit My Mommy! provides treatment guidelines to address the behavioral and mental health problems of infants, toddlers, and preschoolers whose relationships have been disrupted by violence. The guidelines were developed from evidence-based approaches to therapy. This publication is available at www.zerotothree.org/bookstore/

**Watch, Wait and Wonder**

Watch, Wait and Wonder is a dyadic child led psychotherapeutic approach that has been empirically tested and is used with children ages birth-9 with relational, behavioral and regulatory, and developmental problems. For more information, visit www.hincksdellcrest.org/institute/documents/WWWAnnualPreface3.pdf.

**”Ecosystemic Play Therapy”**

”Ecosystemic Play Therapy” (EPT) can be seen as a framework for play therapy rather than a specific modality. As such many modalities are integrated into the EPT framework depending on the needs of the client and the preference and training of the therapist. In the case example components of several distinct therapeutic approaches (including Theraplay®, Watch, Wait, & Wonder®, and social learning theory) are thoughtfully integrated in the EPT assessment and intervention. For more information about ”Ecosystemic Play Therapy,” visit www.wested.org/cpei/limbergcasestudy.pdf.
Infant Parent Program/Daycare Consultants: A System of Care in Itself

The Infant–Parent Program is an infant mental health program that began in San Francisco in 1979 as an outgrowth of a pioneering project in Ann Arbor, Michigan. Although part of the University of California San Francisco, it is in many ways a community program based at the city/county hospital and largely supported by the Children, Youth, and Family Section of San Francisco’s Community Behavioral Health Services. The Program’s central focus has always been intervention in difficulties in the relationship between infants and toddlers and their parents. In the 1980’s, program staff came to recognize the expanding importance of another set of relationships in the lives of young children – the relationships with those who care for them in child care. So 15 years ago, the Infant–Parent Program added its Daycare Consultants component. This service provides mental health consultation to child care settings, offering both case–centered and programmatic consultation, as well as on–site therapeutic groups for preschoolers at three centers. An increasing number of children and families have benefited from a carefully coordinated transition from intensive psychotherapeutic services to consultation on the child care site. For more information, visit www.wested.org/cpei/sfcasestudy.pdf.

"Out of My Head" © A Personal History Bag ©

The Preschool 0–5 Program in Riverside California focuses on social–emotional development of children and the relationships they have with their family members and caregivers. Children are identified through a screening project utilizing a collaborative team approach between the Public Health Department and the Mental Health Department with the aid of the Devereux Early Childhood Assessment (DECA). The DECA examines four areas of child development: Initiative, Self–Control, Attachment, and Behavioral Concerns to give an overall measure of Total Protective Factors. When concerns are found in these areas outreach is made directly to the families. Here is where the opportunity for intervention begins. Over the course of treatment, individual and specialty needs are discovered and addressed. For more information about "Out of My Head," visit www.wested.org/cpei/girardcasestudy.pdf.
ENDNOTES


2. Ibid.

3. Ibid.


9. Ibid.


14. Casa, Paula


16. Casa, Paula

17. Perry, Bruce, Neurodevelopmental Impact of Childhood Violence, Safe from the Start.


19. Perry, Bruce.


23. Ibid.


34. Standards of Practice for Mental Health Services in Partnership with Early Care and Education in Alameda County. Alameda County Early Childhood Mental Health System Group Report. www.co.alameda.ca.us/childcare/ecmhpject.htm.
