ZERO TO THREE®

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Journal of ZERO TO THREE: National Center for Infants, Toddlers, and Families

Emerging Issues in Infant Mental Health

From the Irving Harris Foundation Professional Development Network

Diversity-Informed Infant Mental Health Tenets

Strategies for Influencing Public Policy

Topics in Infant Mental Health Research

THIS ISSUE AND WHY IT MATTERS

This issue of Zero to Three, *with Guest Editors Kandace Thomas of the Irving Harris Foundation and Joy Osofsky, a ZERO TO THREE Board Member and past President, offers a diverse collection of articles highlighting emerging issues in infant mental health. The contributors, along with ZERO TO THREE, are members of the Harris Professional Development Network (PDN) who work individually and collectively to help grow, expand, and deepen the field of infant mental health. The shared history between ZERO TO THREE and the PDN underscores our mutual commitment to strengthening the infant–family field and promoting the importance of social and emotional well-being.*

Stefanie Powers
Editor

This edition of the *Zero to Three* Journal is a celebration and recognition of some of the latest work in the infant mental health field and features research, policy, and practice efforts happening across the United States and in Israel. As noted, this issue highlights the work of the PDN, created and facilitated by the Irving Harris Foundation. Irving Harris, founder of the PDN and passionate early childhood advocate and philanthropist, was influential in the early history of ZERO TO THREE. The issue illustrates how much the field of infant mental health has evolved since the founding of this network. The articles highlight best practices in reflective practice, supervision, training, and leadership development. They showcase the replication efforts of high-quality infant mental health programs and practices including Child-Parent Psychotherapy, Fussy Baby, and Minding the Baby. The authors also demonstrate how to leverage private funding to advance a public policy and advocacy agenda to improve state systems and practices for young children. They provide a glimpse into the latest research and how some have worked to infuse infant mental health best practices into other systems.

While work in the infant mental health field is celebrated here, the issue also provides an opportunity to introduce an expanded vision for the field—a vision for infant mental health to be more intentional about addressing some of the intractable injustices in society created by racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression. To that end, the Diversity-Informed Infant Mental Health Tenets offer guiding principles outlining standards of practice that point the way to a just society through engaged professional practice. The Tenets are an opportunity to remind us all that infant mental health is work toward social justice. In addition, this special issue intentionally highlights some of the work of younger leaders in the field as a reflection of the PDN's commitment to leadership development and inclusion.

The work of the PDN does not stand alone. Although this issue reflects a network within the infant mental health field, it by no means represents the entire field or all of the work of the field collectively. Many others have contributed greatly to infant mental health by replicating innovative direct service programs, working on national and state efforts to build credentialing systems, advocating for infant mental health services at the state level, or engaging in research. We celebrate all those whose work contributes to the growth of the field.

Kandace Thomas and Joy D. Osofsky
Guest Editors

ZERO TO THREE®
National Center for Infants, Toddlers, and Families

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The Irving Harris Foundation's Investment in the Professional Development Network

PHYLLIS GLINK
Irving Harris Foundation
Chicago, Illinois

Irving Harris was a truly remarkable man who was savvy in business and visionary in his philanthropy. Driven by a deep commitment to social justice and equity—and inspired by the Jewish tenet Tikkun Olam, "to repair the world"—Irving dedicated much of his life to strategic grantmaking, ensuring that every child was born by parents and to communities ready to nurture that child's successful growth and development. Irving advanced this goal by investing in leadership development and training to strengthen the field of infant mental health's (see Osofsky & Thomas, this issue, p. 9, for a definition of infant mental health) infrastructure; the development and replication of innovative, evidence-based programs and services; and public policy and advocacy that promoted the realignment of public resources to support high-quality, comprehensive services and systems that support the mental health and development of very young children and their families. Irving was at the forefront of building the infant mental health and early learning fields. He was driven by a clear understanding that investing early in human capital development would result in significant returns on public and private investments and, therefore, the greatest benefit to society.

Irving Harris left a distinct philanthropic legacy. He was respected as much for his approach to grantmaking as he was for the effectiveness of his grantmaking. The Irving Harris Foundation's board continues to carry on philanthropy inspired by his vision, philosophy, and strategy. Undergirding Irving's philanthropy are a set of core values that continue to shape the Foundation's investment strategy and have allowed us to cultivate a deeper and more sustained impact on the field. As the Foundation's 2009 Mission and Values Statement cited, the Foundation's core values and strategies include the following:

- **Develop leadership and training.** From the beginning, Irving identified and invested in leaders and innovators who he believed were in a position to have a significant influence on the field—whether in practice, research, training, or policy—and gave them the resources and flexibility they needed to be creative change agents. He also supported training as a long-term strategy to build a high quality infrastructure to support and sustain the field. The Foundation continues to support and nurture leaders and invest in training as core impact strategies.
- **Leverage resources to drive systemic change.** Irving understood that there is not enough collective private funding to address the complex issues facing at-risk families. The Foundation intentionally seeks to leverage its resources with other public and private funds to ensure broader impact. The Foundation tries to leverage field knowledge by promoting best practices through training, replication, and systems integration in an effort to narrow the gap between what we know and what publicly funded systems in the U.S. do to support high-risk families with very young children.
- **Take risks.** Irving took calculated risks in his grantmaking, recognizing that the greatest gains would occur only if

Photo: Kathy Richland Photography. Property of Erikson Institute.

Irving Harris was driven by a clear understanding that investing early in human capital development would result in significant returns on public and private investments and, therefore, the greatest benefit to our society.

he and others in the field experimented and pushed the boundaries of what was accepted practice and policy. He managed the risk by remaining steeped in the knowledge base of the field, partnering with field leadership and leveraging his funding—often by creating public–private partnerships in advance of new initiatives. The Foundation continues to promote innovative practice to advance the field.

- **Focus on prevention to maximize impact.** Irving's philanthropy was focused sharply on infant mental health, early childhood development, and child and family policy with an emphasis on prevention. Informed by research and best practice, he understood that he needed to take a comprehensive and holistic approach in order to address the complex issues affecting young children, their families, and their communities. The Foundation's continued focus on investing early in human capital development reflects our deep commitment to prevention and early intervention as a core strategy to ensure equal opportunity and access for all children and families.
- **Act early and proactively.** Irving—and, now, the Foundation—seeks opportunities to use our philanthropy and influence to be change agents. The Foundation staff works with our grantees and government partners to identify gaps and needs in the field and to develop strategic, innovative, long-term approaches to address these needs through training, leadership development, the development and replication of innovative programs, communication efforts, and public policy.
- **Be responsive to community and grantee needs.** The Foundation works tirelessly to understand the true needs and challenges being faced by our grantees and by the communities whom we are trying to support through our grantmaking. We want to know not only what is working but also, through open dialogue with our grantees and community partners, what the barriers are to achieving real change for children and families. By serving on local, state, and national committees—as opposed to the more traditional "top-down grantmaking"—the Foundation staff develops shared strategies with our grantees.
- **Value relationships and work in partnership and collaborations.** Most important, Irving and the Foundation have always placed a very high value on building and sustaining strong relationships with grantees, philanthropic and public partners, and leaders in the field. We have invested in infant mental health and early learning and development for more than 40 years and have remained committed to our core grantees for long periods of time.

This overview of Irving B. Harris and the Foundation's strategic approach to grantmaking in the infant and early childhood field is critical to understanding and truly appreciating why the Foundation has made such a major, long-term investment in the Professional Development Network (PDN).

History of the PDN

The PDN evolved out of Irving's growing appreciation for the importance of supporting very young children's mental health and development and the recognition that there was a critical need to strengthen the infrastructure of this new field through multidisciplinary training and leadership development. His growing understanding of the importance of investing in infant development was nurtured through his relationships with some of the early leaders in the field, many of whom he met through his participation in the creation of and service to ZERO TO THREE: National Center for Infants, Toddlers, and Families. To move the field forward, Irving proactively sent letters to a handful of experts, asking them to reflect on how they would use $50,000, $100,000, or $200,000 a year to build the infrastructure of the infant mental health field through training and leadership development. At the time, the most pressing need was to train highly competent mental health professionals in how to provide relationship-based treatment and support to families with very young children. Irving's request was not prescriptive but, rather, was open ended, challenging his colleagues to think creatively about how to best develop the mechanisms to professionalize the field. Irving awarded three multiyear grants that provided enough financial security to the leaders of these programs to take risks as they developed their fledgling programs.

Over the next 6 years, the Foundation added more sites using the same process of identifying leaders and innovators across disciplines—those individuals who potentially could have great influence on the infant mental health field. Sites were asked not only to train pre- and post-doctorate fellows and others within their institutions but also to look for opportunities to strengthen mental health leaders in their community who were serving pregnant women and families with very young children. To foster cross-site learning and fertilization, the Foundation encouraged and supported sites to convene so that they could use one another to better understand and address the challenges and barriers affecting their work, identify and address gaps and needs in the field, and share resources. Foundation staff and leaders from ZERO TO THREE participated in these meetings as a

way to ensure that they translated the lessons to the broader field and they capitalized on opportunities for field movement. These meetings, which were more frequent in the early years of the grants and now occur annually, have been incredibly important in strengthening and expanding the individual and collective impact of the PDN sites (see box The Irving Harris Foundation Professional Development Network) and, subsequently, the Foundation's investment.

Current Needs of the Field

As the infant mental health field has evolved, so have the needs of the field. Although there remains a need to train leaders to work in the field, training alone will not address the complex needs of isolated and at-risk families. PDN sites have been extremely successful over the last 20 years in helping to establish the field and advance an understanding of the importance of investing in young children's social and emotional health and well-being. The Foundation believes that the collaboration among PDN sites is a key component of this success because it leverages other public and private investment, advances research and best practices, contributes toward policy gains, and results in trained individuals who embrace and advance the field. The PDN now represents an important component of a much more robust field of infant mental health training and leadership development that is contributing to advancing best-practice models that strengthen the field. Yet, there continue to be vast unmet needs across the socioeconomic spectrum of young children and their families, with particularly unacceptable gaps in access to and quality of mental health and early learning services for poor and minority children. The training of infant mental health providers from underrepresented minority backgrounds continues to lag dramatically behind the need, and professionals in the infant mental health field must understand how to better engage those who are emerging from institutions of higher learning in the early childhood field.

In addition, many young children needing mental health intervention are not referred to mental health clinics, and if they are, few clinicians have the skills and training to address their needs. These children are more often found in child- and family-serving systems such as child care settings, pediatric clinics, and foster care. Similarly, many of these children's parents are often undereducated, depressed, and isolated, all of which make it difficult for them to access the services and support systems that they need to effectively parent their children. A third worrisome trend in the field of infant mental health is that violence-related trauma is a

Irving Harris Professional Development Network

The Irving B. Harris Program for Infants, Toddlers, and Families in Israel
Bar-Ilan University
Ramat Gan, Israel
www.development-infants-toddlers.org

Division of Developmental and Behavioral Pediatrics
Boston Medical Center/Boston University School of Medicine
Boston, MA
www.bmc.org/pediatrics-developmentalbehavioral.htm

Child Trauma Research Program
University of California San Francisco
San Francisco, CA
http://psych.ucsf.edu/research.aspx?id=1554

Harris Early Childhood Mental Health Training Program
Children's Hospital & Research Center Oakland
Oakland, CA
www.childrenshospitaloakland.org

Irving B. Harris Infant Mental Health Certificate Program
Erikson Institute
Chicago, IL
www.erikson.edu

Harris Infant Mental Health Training Institute
Florida State University, Center for Prevention and Early Intervention Policy
Tallahassee, FL
www.cpeip.fsu.edu

Irving Harris Early Childhood Training Center
Hebrew University of Jerusalem
Jerusalem, Israel
http://harris.huji.ac.il/index.html

Infant–Parent Program
University of California San Francisco
San Francisco, CA
http://infantparentprogram.org

Institute for Infants, Children, & Families
JBFCS
New York, NY
www.jbfcs.org

Harris Center for Infant Mental Health
Louisiana State University Health Sciences Center
New Orleans, LA
www.medschool.lsuhsc.edu/psychiatry/research.aspx

Harris Infant and Early Childhood Mental Health Training Institute
Southwest Human Development
Phoenix, AZ
www.swhd.org

Family Support Program
The University of Chicago School of Social Service Administration
Chicago, IL
www.ssa.uchicago.edu

Tulane Institute of Infant and Early Childhood Mental Health
Tulane University
New Orleans, LA
www.infantinstitute.com/

Irving Harris Program in Child Development and Infant Mental Health
University of Colorado School of Medicine
Anschutz Medical Campus
Aurora, CO
www.medschool.ucdenver.edu/psychiatry/harrisprogram

Irving Harris Training Programs
University of Minnesota
Minneapolis, MN
www.cehd.umn.edu/CEED/certificateprograms/iecmh/default.html

Barnard Center for Infant Mental Health & Development
University of Washington School of Nursing
Seattle, WA
www.cimhd.org

Provence Harris Infancy and Early Childhood Programs
Yale Child Study Center
New Haven, CT
http://medicine.yale.edu/childstudy/index.aspx

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Investing early in human capital development will result in significant returns on public and private investments and, therefore, the greatest benefit to society.

recurrent factor in the lives of millions of very young children and their families, but the field as a whole has been slow in responding to this situation with specialized intervention approaches and needed systems change. These are only a few of the complex issues that continue to face at-risk infants, toddlers, and their families today.

Given these needs, the Foundation—in partnership with leaders in the PDN—expanded the focus of the PDN sites' work from an emphasis that was almost entirely on training to a more expanded set of goals. These goals include the development and replication of innovative, evidence-based model programs; more intentional efforts to change the way in which child- and family-serving systems provide infant mental health and early learning services; and, most recently, increased efforts to influence public policy at the state and federal levels. Overarching all of this work has been an intentional and sustained commitment to strengthening diversity-informed infant mental health services and practices in the field by promoting minority leadership development so that the Foundation and the PDN sites create a pipeline of leaders that more aptly reflects the underrepresented communities in which infant mental health professionals work.

What We Have Learned

The Foundation has learned a lot from the infant mental health field and from the incredible individuals with whom we have been blessed to work. We have reinforced the value of forming and nurturing relationships that are trusting and responsive through collaborative partnerships with our grantees. These relationships have helped inform our grantmaking and have enabled us to identify and respond more effectively to the challenges in the field. From Jeree Pawl, we learned that "how we are is as important as what we do" (Pawl & St. John, 1998). We have tried to invest in ways that respect and support our grantees' ability to innovate and influence the field, an action that has, in turn, allowed us to maximize our impact. We have remained strategically focused on advancing the best interests of at-risk pregnant women, infants, and toddlers over a long period of time, recognizing that long-lasting and significant change often takes a developmental trajectory much like that seen in human development. We invest early, and then we nurture, support, and respond to our grantees as they and the field develop the capacity to transform practice, systems, and, we hope, policy. Having had a clear vision and strategy, and sticking with it over time—while also being flexible enough to shift as the needs of the field "move" around policy or systems or research—has allowed the Foundation to have an optimal impact. If Irving were alive today, he would marvel at how the PDN, with the support and guidance of the Foundation, has helped transform the infant mental health and child trauma fields.

Phyllis Glink, *MPP, is executive director of the Irving Harris Foundation, a family foundation located in Chicago, Illinois. She has worked for the Foundation since 1996, developing, implementing, and managing the Foundation's work in the areas of early childhood development, child and family welfare, and Jewish and community giving. As the executive director, Ms. Glink works closely with the Foundation's partners in the nonprofit, advocacy, philanthropy, and government communities to ensure that the Irving Harris Foundation's grants are having an optimal impact on the fields of early childhood development, infant mental health, and public policy. Ms. Glink serves on many governing councils and advisory committees, including the Executive Council of the Governor of Illinois' Early Learning Council and the Illinois Department of Human Services Advisory Council on Child Care, where she participates on the quality committee. Ms. Glink serves on the Steering Committee for the Early Childhood Funders' Collaborative and on the Core Advisory Group for the Early Learning Challenge Collaborative. She helped develop and launch the multistate Building Early Learning Systems in States Initiative, an early childhood systems building initiative of the Early Childhood Funders Collaborative. Ms. Glink is the national chair of Health Connect One's Doula Leadership Institute, co-chairs the Steering Committee for the new Illinois Early Childhood Leadership Fellowship, and serves as a member of the Chicago Children's Museum's Early Childhood Advisory Committee.*

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What Is Infant Mental Health?

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Note: *Many individuals and groups in the infant mental health field, including ZERO TO THREE, have defined and described what is meant by infant mental health. For this special issue of the* Zero to Three *Journal, we have reviewed what has been written previously and, based on the different interpretations, are offering the following definition.*

Infant mental health is defined as the developing capacity of the infant and young child (from birth to 5 years old) to experience, express, and regulate emotions; form close and secure relationships; and explore the environment and learn, all in the context of cultural expectations. Infant mental health, as a field, is multidisciplinary, requiring expertise and conceptualization from a variety of different disciplines and perspectives including research, clinical practice, and public policy. A major premise of infant mental health is that babies' emotional, social, and cognitive development and competencies unfold in the context of their caregiving relationships; thus supporting both the infant and the primary caregiver is crucial to optimize the young child's functioning. Young children are exquisitely sensitive to the emotional well-being and life circumstances of their caregivers, which can profoundly affect the quality of infant–caregiver relationships. Winnicott vividly described the crucial nature of the caregiver–infant relationship, reflecting that "there is no such thing as a baby" (Winnicott, 1964, p. 88)—meaning that if you describe a baby, you are actually describing a baby and someone. Therefore, a baby cannot exist alone, but only in a relationship. Understanding the cultural context of the infant–caregiver relationship is very important because mental health of young children may be understood and interpreted differently in various cultures. Families live in many different communities with varying values and expectations about children's development. Families also express themselves and their beliefs in different ways, and they engage in child-rearing practices that are consistent with their culture and beliefs.

Unfortunately, the term "infant mental health" can be confusing for some people because it may be understood as translating into "mental illness." Others may not appreciate that babies and toddlers have the capacity to experience complex emotions. Supportive relationships with adults, particularly primary caregivers, are crucial both for physical survival and healthy social and emotional development. In order to understand the mental health of a young child, one needs to first consider the baby's experiences over time within the context of important relationships with parents and other caregivers. Major objectives of infant mental health include minimizing the suffering infants may experience and enhancing their competence.

Public policy plays an integral role in the conceptualization of infant mental health interventions because society plays a pivotal role in promoting consistent, reliable, protective, and nurturing caregiver–child relationships which are essential for raising developmentally competent children. This can include direct supports for families as well as supports to enhance the quality and sensitivity of the systems that serve them including child care and early education, pediatrics, child welfare, mental health, the judicial system, and others. One further note: Because the caregiver plays a crucial role as a partner in the infant and young child's social and emotional development, the caregiver's emotional well-being is central to the infant's emotional well-being. Further, the nature of the child–caregiver relationship is greatly influenced by the nature of the caregiver's own childhood experiences and psychological history including the intergenerational nature of attachment relationships and behavior. Selma Fraiberg, who has been credited as one of the inspirations in the development of the field of infant mental health and the early approaches to infant–parent psychotherapy, emphasized that the work of the infant mental health specialist is to help find ways to mother the mother so she can be a mother to the baby (Fraiberg, Adelson & Shapiro, 1975).

Fraiberg, S, Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry*, *14*(3), 387–421.

Winnicott, D. W. (1964). *The child, the family, and the outside world*. London: Penguin Books.

Transformational Enterprise on Behalf of Young Children in Poverty

Reflections About Irving Harris and the Irving Harris Foundation Professional Development Network

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If we grasp this opportunity, we will have given the world a gift of inestimable value.
—Irving Harris (1996, p. 206)

Irving Harris: Pioneer of "Zero to Three" as a Field

Irving Brooks Harris was a man with a mission, a hero for children, and a leader for a moral society. He cared deeply about people whose race, ethnicity, neighborhood, and related circumstances of birth placed them in the no-exit underclass. This profound commitment to help re-shape society toward justice, melded with his perennially inquiring mind, inevitably led him to the youngest children, especially those born into poverty. Given his strong commitment to support fledglings and their families, Irving Harris provided grants to many types of leaders and helped to nurture many organizations, all of which ultimately created the field of infant mental health and fashioned the Irving Harris Foundation Professional Development Network (PDN).

Governed by an ethical vision, Irving recognized that the quality of relationships in the earliest years makes a difference for good or for ill. Indeed, long before it was confirmed by brain science, Irving Harris perceived that intervening during the first years of life makes a significant difference in long-term outcomes. By investing in research, model programs, training, policy, systemic change, and in ZERO TO THREE, the organization, Irving was a major leader, a force in the creation of what was to become both a movement and a field.

Irving wrote, "I believe that God's gift of brain potential ... is not discriminatory" (Harris, 1996, p. xv) . He was among the first to grasp the fact that to gain traction in the public consciousness, the brains of babies needed to move to the media's center stage. Having begun his efforts for babies when he was in his late 40s, by the time Irving was in his early 80s, momentum for "zero to three" as a field was gathering steam. Rather than relax at this stage of life, Irving wrote his first and only book, *Children in Jeopardy: Can We Break the Cycle of Poverty?* (1996), all the while worrying unremittingly about preparing a workforce to deliver high-quality, integrative, relationally alive services. He would repeat his mantra to anyone who would listen: "One day, government and society will catch on and build programs for little children. What happens if there is no one to lead those programs, no one who really knows what very little children and their parents need? They will fail, and funding for them and their programs will dry up!" The question nagged at him and led him to do a small, idiosyncratic survey also described in Phyllis Glink's article (this issue, p. 5).

Emphasizing that it was only a survey, that we would certainly not be funded, Irving wrote a short letter to eight colleagues on the board of ZERO TO THREE asking what we would do about training in our programs under the following four circumstances: (a) if we had no extra money in the next 5 years; (b) if we had $50,000 a year guaranteed over the next 5 years; (c) if we had $100,000 a year; or (d) if we had $200,000 each over the next 5 years. Three survey recipients replied, Jeree Pawl of the Infant-Parent Program, San Francisco; Linda Gilkerson, Infancy Program, Erikson Institute; and me, having proposed what was to become, with Irving's help, the Institute for Infants, Children and Families, JBFCS in New York City.

A remarkable transformation occurred in Irving's sense of vigor and future. At the age of 83, he decided to assume the executive director's post of his Foundation himself in order to propel and improve training across the myriad early childhood disciplines throughout North America and in Israel and to positively impact early childhood policies in this country. He was a man in a hurry, forcefully driven by each day passing. His first move was to fund the three individuals who had responded to his survey by supporting their program plan while, simultaneously, inviting the others to send him their proposals. Soon afterwards, he hired Phyllis Glink, then a recent graduate of the Harris School of Public Policy Studies at The University of Chicago, to support

[1] *It is with deepest humility and a sense of great honor that I offer my reflections on Irving Harris, the Irving Harris Foundation, and the Irving Harris Foundation Professional Development Network. I write with loving gratitude to every PDN member over all these years—for partnering with vitality, industry, open-heartedness, commitment, and enduring belief in the promise of all human beings—and to the Foundation's leadership, which has bound us together in these many generative ways over time.*

his work at the Foundation, which included expanding the newly created PDN. Being the frank, straightforward individual he was, he included her in everything.

The Irving Harris Foundation

[T]he first few months of life are not a rehearsal. This is the real show.
—Irving Harris (May 3, 1994)

When Irving unexpectedly decided to fund the programs whose leaders had responded to his survey, the three of us already trusted one another professionally through our conjoined work over years as board members of ZERO TO THREE. The very hour after he announced his decision we, with ZERO TO THREE staff, decided to meet on a regular basis to help one another. What a momentous day it was! We recognized that Irving was not only changing the future of our programs and the course of our own lives but that, by funding us and the many others whom he invited to apply for funds, he was accelerating fine training on a large scale, profoundly changing the future for babies in our nation and beyond.

Being funded by Irving was a mission-affirming experience; he placed trust in the leaders in whom he invested. And, to those who worked alongside him, he was an unintended but exemplary mentor. He lived what he believed in, and led by example. He worked intensively and was a role model for all of us. For example, he never hesitated to fulfill his longstanding date as Visiting Scholar at our Institute flying into New York City within weeks of the attacks on the World Trade Center, lending us all a sense of future again.

Following Irving's splendid model, the leadership team of the Foundation carries on with industry, commitment, collaboration, teamwork, and vision. Like him, Phyllis Glink and the Foundation staff continue to lead by modeling direct, open communication leavened always by fairness, ethical ideals, loving enthusiasm, and enormous respect. The Irving Harris Foundation has been indefatigable in fighting prejudice and encouraging diversity, setting an example that is being followed by PDN members. These members are committed to identifying people from underrepresented racial and ethnic groups, encouraging them to lead and work at all levels and to participate in training within our organizations. Moreover, the Foundation has motivated PDN members to attend to the fathers of the children—the parent who is too often inadvertently diminished and or invisible within our female-dominated specialties. And, recognizing that trauma underlies many so-called challenging behaviors, The Irving Harris Foundation's leadership has emphasized and encouraged member organizations to prepare providers to know about and work with trauma. They also challenge member organizations to become more active politically at the local and state levels as well as to write this issue for *Zero to Three* that developed and highlights the new Diversity-Informed Infant Mental Health Tenets (St. John, Thomas, & Noroña, with the Irving Harris Foundation Professional Development Network Tenets Working Group, this issue, p. 13) and elaborates upon collaborative efforts that are being made throughout the field.

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The Foundation has motivated PDN members to attend to the father of the family—the parent who is too often inadvertently diminished and or invisible within our female-dominated specialties.

The PDN as Change Agent and Transformational Enterprise

We particularly have to train specialists in infant care, both to assess infant delays and development and to provide therapy for them. The nation has been extremely slow in the training of sorely needed public health nurses, nurse practitioners, early childhood development specialists, social workers, and paraprofessionals in all these categories
—Irving Harris, from *Children in Jeopardy* (1996, p. 200)

The PDN is an extraordinary mixture of committed professionals. All of the programs and the individuals who lead them provide training to their communities and beyond. To date, the PDN has expanded to 16 programs in the United States and two in Israel and now represents a subset of the greatly expanded and increasingly vibrant field of infant mental health training and leadership development.

Over the years since its inception in 1993, when the first three members plus ZERO TO THREE staff met in one another's homes, the vision of the PDN shifted from an emphasis on getting advice from one another regarding various training, curricular, and administrative challenges to discovering and addressing hard questions in order to learn from, inspire, and provoke new ideas with one another. The agenda, loose enough for new topics to emerge, is co-constructed in the months leading up to the meeting by a committee of Foundation staff and PDN volunteers. Recently, for example, Network members have asked, "What are the pros and cons of the growing emphasis on evidence-based practice?" and "On what basis should an agency, a system, or a state that wants to work toward comprehensive services select a model?" Members also recently shared ideas about how to work with perpetrators of family violence in the context of child–family work.

When PDN members are asked what the group means to them, their replies include the following themes:

- "I really appreciate that the PDN does not seem hierarchical."
- "The regularity of meeting annually and the nonjudgmental, benevolent atmosphere connects us and allows us to share 'real' feelings."
- "The PDN calls on the three essential functions of relationships—*security* (providing a secure base, with comfort and reassurance in times of stress and doubt); *joyful sharing* (which includes fun, thinking, humor, problem-solving, storytelling, reminiscing); and *guidance and support*—by scaffolding and professional nurturing, to help me on

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The PDN may be understood as a group of professionals who, through their mutuality and conjoined effort, can better fulfill their collective yearning to create a safer, more nurturing world for the littlest children and their families.

> my path from (what felt like) beginner to ever-aspiring expert, with amazing sensitivity and respect."

Along these lines, the PDN can also be characterized as a "learning organization" and as an agent of change. Peter Senge (1990) stated,

"The change that is required will not only be in organizations, but also in ourselves . . . . Our organizations work the way they work, ultimately, because of how we think and how we interact. *Only by changing the way we think can we change deeply embedded policies and practices. Only by changing how we interact can shared visions, shared interactions, and new capacities for coordinated action be established"* (p. xiv).

One PDN member commented,

It is energizing to be part of a community of superb professionals with similar interests but from different disciplines, sites, and cultures who can compare and contrast approaches, values, challenges, and the like. Coming together once a year to immerse ourselves in issues of common interest increases our reflective capacities, renews our connections, and recharges our batteries.

The PDN challenges its members to think deeply, making connections across numerous complex domains, while providing a welcoming community of support to meet that trial together. Indeed, it does so by engendering "mutuality," "a way of seeing, being, and acting in a world that was founded on the belief that human growth is a shared process" (Leonard, 2005, p. 42).

One member wrote:

Quite simply, to me, the PDN meetings provide the space to both imagine, and delve into, the work the way it should be and could be, where both the process and the product are valued. The annual PDN meeting provides me with an annual dose of hope that the quality and complexity of the work matters, has a home and parents who listen.

As a network of people and programs, some agencies in the PDN have employed talented professionals from other PDN programs when the individuals decided to move to different locales. Some network members work together across large distances, cross-fertilizing one another's programs.

By emphasizing the potential of affect and aspiration in mobilizing social forces within training contexts, the PDN has become a transformational enterprise—that is,

laboring together on something people care about—something that fulfills their personal, professional, and programmatic vision—helps people feel allied, intentional, and alive . . . when each person's perspective is deeply valued and palpably linked to mission, working and learning together over time as colleagues becomes a transformational enterprise. (*Shahmoon-Shanok, Lapidus, Grant, Halpern, & Lamb-Parker, 2005, p. 479*)

In these ways, the PDN may be understood as a group of professionals who, through their mutuality and conjoined effort, can better fulfill their collective yearning to create a safer, more nurturing world for the littlest children and their families.

The other authors and I very much hope that this issue of *Zero to Three*, contributed to and edited by PDN members, inspires the field of infant mental health by reflecting Irving Harris's fervent allegiance to the youngest children and their families, especially those in poverty. As he aptly put it, "Kindergarten is much too late for us to to start worrying if a child is ready to learn" (Harris, 1996, p. xvii). With Irving Brooks Harris' well-lived life in mind and soul, let's go forward with renewed potency, clarity, and caring—together.

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Infant Mental Health Professional Development

Together in the Struggle for Social Justice

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Over the past 30 years, the field of infant mental health has evolved exponentially. Within this multidisciplinary field, practitioners of all kinds—clinicians, researchers, practitioners, and policy makers—all work to ensure the emotional, physical, social, and cognitive well-being of children from the prenatal period through 3 years. The field's work has been elevated partly because of what the science reveals about brain development and early experiences, and other critically important research that demonstrates how a young child's experience can shape long-term outcomes. In the past few years, the field has made great policy gains such as the increased federal funding to support early learning programs, federal funding for home visiting, and other policy efforts that support young children's healthy development.

Significant to this work has been the training, capacity building, and development of innovative programs led by members of the Harris Professional Development Network (PDN). Over the past 20 years, the PDN has played a critical leadership role in changing the landscape of services for infants and small children by promoting infant mental health and child development and by integrating core principles of infant mental health into systems and services that work with the most vulnerable children in the United States and Israel. These programs have also created models to work with children in war zones and children facing natural disasters. The PDN has been instrumental in professionalizing infant mental health providers by creating certificate programs, disseminating evidence-based treatment models such as Child-Parent Psychotherapy, and replicating innovative programs such as Minding the Baby and Fussy Baby.

Despite major successes deepening the field, there continue to be vast unmet needs across the socioeconomic spectrum of young children and their families, with particularly unacceptable gaps in access and quality of mental health and early childhood learning services for poor children, many of whom are African American, Latino, or Native American

Abstract

To create a just and equitable society for the infants and toddlers with whom its members work, the infant mental health field must intentionally address some of the racial, ethnic, socioeconomic, and other inequities embedded in society. The Diversity-Informed Infant Mental Health Tenets, presented and discussed here, are guiding principles outlining standards of practice in the field and pointing the way to a just society via engaged professional practice.

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There continue to be vast unmet needs across the socioeconomic spectrum of young children and their families.

or represent other nondominant racial and ethnic communities. In many cases, professionals in the infant mental health field are disproportionately Caucasian, while many of the most vulnerable young children are children of color. In order to create a just and equitable society for the infants and toddlers with whom its members work, the field must intentionally address some of the racial, ethnic, socioeconomic, and other inequities embedded in society.

To begin to address these inequities, the PDN, as a group, has made one of its primary goals to deepen the field's commitment to diversity-informed, culturally attuned, inclusive, and equitable practice. To that end, members of the PDN studied some of the incisive and influential statements of core values of infant mental health and many ground-breaking innovations addressing diversity and inclusion that were underway across the disciplines and around the globe (see box Irving Harris Foundation Professional Development Network Tenets Working Group). This research revealed that diversity issues tended to be held as an area of specialized knowledge (e.g., infant care practices of a particular cultural group) or as a special skill set (e.g., the idea of "cultural competence"). What was missing was a shared vision of the role played by human diversity in those very principles and practices universally embraced within the field. Certain core principles of infant mental health, such as the importance of early relationships, are difficult to uphold evenly within a society where certain groups and relationships are recognized and revered, while others are discounted or denigrated. It became clear that infant mental health is a matter of social justice.

Wide recognition exists regarding the urgent necessity of protecting and promoting the health and well-being of infants and small children. Yet, there are no guidelines for equitably working toward this end given the cultural and institutional barriers based on class, race, and other inequities with which professionals all live and work. Thus, the PDN created the Diversity-Informed Infant Mental Health Tenets (see box) in an effort to offer such guidelines. The Tenets are a working document putting forth a vision of a society and a field in which all infants and toddlers—regardless of racial and ethnic identity, family structure, and ability—will be recognized, respected, and well-served. Most of the Tenets expand on familiar principles of infant mental health. The Tenets attempt to expand the core principles through a diversity, inclusion, and fairness lens. The Tenets are divided into three sections: (a) stance toward infants and families; (b) practice/research field principles; and (c) broader advocacy. Each Tenet is discussed in terms of not only what makes it important, but also what makes it difficult

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to uphold. It is hoped that this working document serves to bring together diverse practitioners committed to eradicating barriers to the healthy development of all infants, families, and communities. We submit that in this sense, professional development in the field of infant mental health means striving for social justice.

Moving Toward Diversity-Informed Practice

The field of infant mental health has come a long way in a short time. Reflecting on the origins of the field, Selma Fraiberg (Fraiberg, Shapiro, & Cherniss, 1980) once recalled the public outrage with which the creation of the first infant mental health program in the nation was met. "When a two-line announcement appeared in our local newspaper that a professor in the department of psychiatry had received a grant from the National Institute of Mental Health for an infant program," Fraiberg wrote, "an irate taxpayer promptly wrote a letter to the editor demanding to know why the taxpayers should be asked to support a crazy woman professor who wanted to put babies on a couch and psychoanalyze them" (p. 49). Discomfort with the phrase "infant mental health" persists today. This discomfort can include the potential implications of the idea of mental illness, as well as concern that the term is too limited in some ways (e.g., it narrows the developmental age range, highlights only some domain(s) of developmental concern, or implies the need for the services of particular professional disciplines to the exclusion of others).

Those who promote the term infant mental health, however, embrace a holistic view of the infant in the context of family and community and intend the phrase to describe the conditions of infants' healthy development and general well-being. To that end, ZERO TO THREE (2001) put forward the following definition of infant mental health, suggesting that this phrase describes

the young child's capacity to experience, express and regulate emotions, form close and secure relationships, and explore the environment and learn. All of these capacities will be best accomplished within the context of the caregiving environment that includes family, community, and cultural expectations for young children. Developing these capacities is synonymous with healthy social and emotional development.

Professionals in the field have developed key infant mental health concepts or principles to guide multiple avenues of effort including policy, research, training, and practice. Examples include the work of the Michigan Association of Infant Mental Health

Diversity-Informed Infant Mental Health Tenets

1. **Self-Awareness Leads to Better Services for Families:** Professionals in the field of infant mental health must reflect on their own culture, personal values, and beliefs, and on the impact racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression have had on their lives in order to provide diversity-informed, culturally attuned services on behalf of infants, toddlers, and their families.

Stance Toward Infants and Families

2. **Champion Children's Rights Globally:** Infants are citizens of the world. It is the responsibility of the global community to support parents, families, and local communities in welcoming, protecting, and nurturing them.
3. **Work to Acknowledge Privilege and Combat Discrimination:** Discriminatory policies and practices that harm adults harm the infants in their care. Privilege constitutes injustice. Diversity-informed infant mental health professionals work to acknowledge privilege and to combat racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression within themselves, their practices, and their fields.
4. **Recognize and Respect Nondominant Bodies of Knowledge:** Diversity-informed infant mental health practice recognizes nondominant ways of knowing, bodies of knowledge, sources of strength, and routes to healing within diverse families and communities.
5. **Honor Diverse Family Structures:** Families define who they are comprised of and how they are structured; no particular family constellation or organization is inherently optimal compared to any other. Diversity-informed infant mental health practice recognizes and strives to counter the historical bias toward idealizing (and conversely blaming) biological mothers as primary caregivers while overlooking the critical child-rearing contributions of other parents and caregivers including fathers, second mothers, foster parents, kin and felt family, early care and educational providers, and others.

Practice/Research Field Principles

6. **Understand That Language Can Be Used to Hurt or Heal:** Diversity-informed infant mental health practice recognizes the power of language to divide or connect, denigrate or celebrate, hurt or heal. Practitioners strive to use language (including "body language," imagery, and other modes of nonverbal communication) in ways that most inclusively support infants and toddlers and their families, caregivers, and communities.
7. **Support Families in Their Preferred Language:** Families are best supported in facilitating infants' development and mental health when services are available in their native languages.
8. **Allocate Resources to Systems Change:** Diversity and inclusion must be proactively considered in undertaking any piece of infant mental health work. Such consideration requires the allocation of resources such as time and money for this purpose and is best ensured when opportunities for reflection with colleagues and mentors as well as ongoing training or consultation opportunities are embedded in agencies, institutions, and systems of care.
9. **Make Space and Open Pathways for Diverse Professionals:** Infant mental health workforces will be most dynamic and effective when culturally diverse individuals have access to a wide range of roles, disciplines, and modes of practice and influence.

Broader Advocacy

10. **Advance Policy That Supports All Families:** Diversity-informed infant mental health practitioners, regardless of professional affiliation, seek to understand the impact of social policies and programs on diverse infants and toddlers and to advance a just policy agenda for and with families.

Developed by the Irving Harris Foundation Professional Development Network Tenets Working Group

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In recent years, the importance of culture in influencing infant and family experience has been widely recognized.

(Weatherston, 2002) to develop practice standards for infant mental health specialists; (California Center for Infant/Family and Early Childhood Mental Health; Heffron, 2011) to provide training guidelines and a professional endorsement system; and the California Interagency Coordinating Council on Early Intervention (2010) to develop practice standards for early intervention personnel. In reviewing knowledge bases from multiple disciplines, Zeanah and Zeanah (2009) identified points of consensus that also serve the function of guiding principles.

There are consistent themes among these documents. Early experiences, development, and relationships are of special importance throughout the life span. When constitutional or contextual vulnerabilities, or both, are present, children and families benefit from services and supports that are collaborative with them and informed by multidisciplinary perspectives. The field has considerable science knowledge and practice experience to support translating these principles into action.

In the early decades of the field—the "color blind" years—writing tended to focus on an imagined universal infant without regard to the sociocultural and historical-political context as a shaping force. In recent years, the importance of culture in influencing infant and family experience has been widely recognized and many authors note the importance of considering culture in planning and implementing interventions in support of infants, toddlers, and their families. The groundbreaking report of the National Research Council and Institute of Medicine (2000) on the science of early childhood development asserted that "culture influences every aspect of human development and is reflected in childrearing beliefs and practices designed to promote healthy adaptation (p. 25)," but concluded that while this basic concept is compelling, "the database is thin and the imperative for extensive research is clear." With respect to research, the Council noted several challenges to studying the contributions of culture to parenting and child development, including lack of diversity in the children and families on whom research has been conducted as well as the need for far greater integration across the relevant disciplines (e.g., anthropology, ethnography, and sociology as well as the more typically represented early childhood fields) in research terminology, design, and practice. With respect to service systems and delivery, the Council articulated several characteristics regarding cultural competence. These included identifying underserved groups and eliminating culture-based barriers to service provision; monitoring the cultural appropriateness of assessment, research, and intervention procedures for the target families; and facilitating policy planning, staff training, and community participation in order to ensure the development, delivery and maintenance of culturally competent services.

The notion of cultural competence has been transformative within the field of infant mental health and across the disciplines that comprise it, bringing urgent attention to the necessity of building awareness of the influence of culture on practitioners, families, institutions, and systems (Maschinot, 2008). Yet some have noted that important components of human diversity that must also be considered and addressed in infant mental health work fall outside of the category of culture. For example, Ghosh Ippen (in press) has suggested that "culture, while of critical importance, is [just] one factor among many to consider" and points to age, gender, immigration history, culture of origin, acculturation, social class, and trauma history as examples of salient aspects of experience that may not be touched by a cultural competence framework. Furthermore, a focus on culture often implies a focus on the culture of the recipients of infant mental health services, rather than on the influence of intersecting forces of oppression on provider–family relationships, on shaping research designs, or on systems of care more broadly. Ghosh Ippen (2009; Ghosh Ippen & Lewis, 2011) propose an alternate framework—diversity-informed practice—in order to account for these broader issues. She described it this way: "Diversity-informed practice is dynamic, focusing not just on values, beliefs or experiences of a group or individual but on interactions among people with different views. It also involves an understanding of how interactions are shaped by the larger sociopolitical and historical context" (in press). In the present article, the term *diversity-informed practice* is adopted in order to tap these many strata of human experience and strive for the highest possible standard of inclusivity in all spheres of practice: teaching and training, research and writing, policy and advocacy, as well as direct service.

Considering the Diversity-Informed Infant Mental Health Tenets

The Diversity-Informed Infant Mental Health Tenets have been devised to support all those in the field in working toward social justice and inclusivity. The discussion that follows describes each Tenet in the context of the serious impediments a professional faces in striving to uphold it.

1. **Self-Awareness Leads to Better Services for Families: Professionals in the field of infant mental health must reflect on their own culture, personal values and beliefs, and the impact racism, classism, sexism, able-ism, homophobia, xenophobia and other systems of oppression have had on their lives in order to provide diversity-informed, culturally attuned services on behalf of infants, toddlers, and their families.**

The first and arguably the most important step to providing diversity-informed services—is an examination and understanding of one's own background, experiences, and identities. This awareness of one's personal assumptions, values, and biases ultimately allows the practitioner to differentiate between the families served and his assumptions. This awareness, including awareness about personal privilege and societal privilege generally awarded to heterosexual, middle-class majority groups, informs the practitioner's relationship with colleagues and clients, as well as the work the practitioner engages in on behalf of clients. Awareness and consciousness of one's cultural background, beliefs, and biases develop best in tandem with a dedicated effort at understanding others' cultural beliefs and heritage. In this process, the infant mental health practitioner acknowledges the ways in which the "isms" listed here lead not simply to instances of discrimination between individuals but also to institutionalized forms of injustice. Note that this Tenet is closely linked with Tenet #8, which recognizes the critical importance of dedicating agency resources to supporting this important aspect of individual professional development.

Stance Toward Infants and Families

2. Champion Children's Rights Globally: Infants are citizens of the world. It is the responsibility of the global community to support parents, families, and local communities in welcoming, protecting, and nurturing them.

If one embraces the core values and guiding principles of infant mental health discussed in the section above, one is hard pressed to apply them to only certain groups of human infants. One would not say, for example, "relationships matter—for American babies." Rather, it must be recognized that all infants offer and require much, and it is the responsibility of the world community to ensure that caregivers have access to adequate resources that are compatible with family and local cultural values. Diversity-informed infant mental health practice entails cultivating an awareness of the plight of infants locally and around the globe, and fostering their well-being in keeping with one's unique capacities and resources.

The United Nations Convention on the Rights of the Child (Unicef, 2012) created a human rights treaty delineating the civil, political, economic, social, health, and cultural rights of children. It came into force in 1990 and has yet to be ratified by the United States despite it's being embraced almost unilaterally by other members of the United Nations. Many of its articles reflect the notion of infants as citizens of the world, including the simply stated Article 6: "Children have the right to live. Governments should ensure that children survive and develop healthily." Given the large numbers of immigrant cultures in the United States, Article 10 has special significance here. It states that "Families whose members live in different countries should be allowed to move between those countries so that parents and children can stay in contact, or get back together as a family." Diversity-informed infant mental health practice and policy recognizes that love knows no borders and that infants' best interests are served when those who love them are able to care for and protect them.

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Early experiences, development, and relationships are of special importance throughout the life span.

3. Work to Acknowledge Privilege and Combat Discrimination: Discriminatory policies and practices that harm adults harm the infants in their care. Privilege constitutes injustice. Diversity-informed infant mental health professionals work to acknowledge privilege and to combat racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression within themselves, their practices, and their fields.

Infant mental health is a social justice issue because discriminatory policies and practices that harm adults harm the infants in their care. Such practices may limit adults' capacities to protect and nurture the infants in their care in overt or covert ways. For example, prohibitions against interracial marriage in the past, or today against same-sex marriage or marriage among adults with disabilities impedes parents' ability to claim, care for, protect, and provide for their children in material ways and also inflicts psychological wounds for parents that can negatively impact parenting relationships. In addition to overtly discriminatory policies and practices, marginalized groups are routinely subjected to covert forms of oppression. With respect to race, insidious forms of racism include structural racism (as reflected, for example, in the gross overrepresentation of children of color in the child welfare system or the race-based achievement gap that is ubiquitous in education systems across the nation); white privilege; internalized racism; and racial microaggressions (Sue, 2010). Diversity-informed infant mental health practice entails identifying and working to eradicate both overt and covert forms of discrimination within one's personal and professional spheres.

As systems and institutions often reproduce aspects of the forces of oppression that operate in society at large, problematic patterns and divisions of labor can easily be reproduced even within well-meaning infant mental health agencies. For example, higher-status positions may be held by dominant group representatives who may be less sensitive to or invested in combating various forms of oppression, leaving such battles to be fought by professionals representing nondominant groups. Diversity-informed infant mental health agencies and systems of care must work to ensure that professionals representing minority status groups do not shoulder an undue burden (e.g., combating racism or other systems of oppression in

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Those who promote the term infant mental health embrace a holistic view of the infant in the context of family and community.

the workplace, serving especially vulnerable families, striving for inclusivity). Such efforts are shared among all infant mental health professionals and supported by agency and community policies.

4. Recognize and Respect Non-dominant Bodies of Knowledge: Diversity-informed infant mental health practice recognizes non-dominant ways of knowing, bodies of knowledge, sources of strength, and routes to healing within diverse families and communities.

Professionalization processes involve knowledge-production, behavior-regulation, and standard-setting, and foster identification with and investment in each of these. Each professional is a steward of the funds of knowledge and approaches to practice that the professional inherits, but each also has a responsibility to critique, adapt, expand upon, and see beyond inherited ways of understanding and doing things. Rather than seeing themselves as the sole holders of knowledge and sources of healing, diversity-informed infant mental health practitioners listen carefully to the infants and families they serve in order to support them in drawing on endogenous resources. Diversity-informed infant mental health practice involves continually revising professional wisdom in light of the lessons learned from infants and families.

5. Honor Diverse Family Structures: Families define who they are comprised of and how they are structured; no particular family constellation or organization is inherently optimal compared to any other. Diversity-informed infant mental health practice recognizes and strives to counter the historical bias toward idealizing (and conversely blaming) biological mothers as primary caregivers while overlooking the critical child-rearing contributions of other parents and caregivers including fathers, second mothers, foster parents, kin and felt family, early care and educational providers, and others.

Although this Tenet may at first glance appear to be simple to embrace, fully implementing it would entail a radical reworking of infant mental health discourse and practice. As was discussed in the section above, most studies of typical early childhood development have been normed on middle class, able-bodied children of European-American descent. In addition, most of these children represent (or are assumed to represent) nuclear families with heterosexual parents. (It is quite rare to come across an infant mental health text acknowledging the prevalence of gay parenthood that is not specifically addressing an issue related to parental sexual orientation.) Whenever heterosexual, white, middle class, able-bodied nuclear families are represented as the norm and biological mothers are assumed to be the only salient caregivers, historical biases are reproduced and further entrenched. These ideas reinforce barriers to a more accurate and inclusive recognition of the reality of family diversity.

A notable exception is James P. McHale and Elisabeth Fivaz-Depeursinge's (2010) discussion of co-parenting in infancy and early childhood. They state that

since the mid-1990s, there has been an upsurge in both basic and applied research studies of co-parenting, though most published reports have involved two-parent Western nuclear families headed by children's mothers and fathers. This has been an unfortunate, unnecessarily limiting constraint, because co-parenting alliances exist in all families where more than just one person assumes responsibility for a child's care and upbringing (p. 354).

McHale and Fivaz-Depeursinge go on to state clearly and inclusively that "in heterosexual two-parent family systems, the key co-parenting figures will be the child's mother and father. In gay and lesbian two-parent family systems, it is the two women or the two men raising the child together" (p. 361). In recognition of the unequivocal findings of decades of empirical research demonstrating that there are no adverse child outcomes associated with gay parenthood (American Psychological Association, 2005; Gatrell & Bos, 2010), diversity-informed infant mental health discourse follows the example of McHale and Fivaz-Depeursinge in using inclusive language to redress the historical tendency in the literatures that comprise the field to either omit any reference to gay people and their families (rendering them invisible) or represent them in terms of pathology. Diversity-informed infant mental health agencies review program materials, such as intake forms, to ensure that inclusive terms such as "parent or guardian" are used rather than the standard heteronormative structure of "mother and father." Logos, flyers, posters, and other imagery are also examined with an eye toward heteronormativity versus inclusivity.

Along similar lines, diversity-informed infant mental health practitioners recognize that single parent families, adolescent parents, divorced parents, parents with disabilities, extended kin networks, and other nondominant parental and family constellations have often been erroneously assumed to provide less optimal child-rearing environments than heterosexual, able-bodied nuclear families. Often adversity factors disproportionally affecting particular parenting groups (e.g., higher rates of poverty associated with adolescent parents) are conflated with those parents' competency, resulting in the idea that it is a parent's age rather than his or her socioeconomic status that poses a "risk" with respect to child well-being.

Diversity-informed infant mental health practitioners combat such discrimination and stereotyping by affirming and including a wide range of family structures and learning directly from families which adults are important in the child's caregiving circle.

Embracing Tenet #5 entails a radical reworking of long-held discursive conventions and structures of thought. The idea of "the mother" as primary caregiver runs deep not only within the professional literatures comprising the field of infant mental health, but across artistic and popular cultural media, and throughout society at large. And indeed, in many instances biological mothers do provide disproportionate amounts of infant care and do hold positions of unique and inestimable importance for developing children. But it is readily recognized that while an infant requires such devoted caregiving in order to survive and thrive, this caregiving need not be provided by a biological mother. Adoptive mothers, fathers, grandmothers and grandfathers, aunts and uncles, other "felt family," or psychological parents with no blood relation to a child may successfully assume the role of sole or primary caregiver or may be critical members of a caregiving network.

When professional infant mental health literature continues to refer to primary caregivers as mothers by default, it reinforces this dominant norm as universal and optimal, lending professional authority and sanction to this construct. One will often encounter a footnote on the first page of a professional paper addressing some aspect of parenting that reads something like this: "While the term 'mother' is used in this article to refer to the primary caregiver, the authors recognize that fathers and others sometimes serve in this capacity..." A caveat or disclaimer such as this stops short of truly including fathers and other potential important caregivers. In fact, in an insidious way it excludes them and justifies it by suggesting that their contributions are exceptional, special case instances—literally marginal. In this way infant mental health discourse tends to serve a "gatekeeping" function (Pruett, 1997), regulating and undermining the involvement of fathers and others in child rearing by reproducing, naturalizing, and romanticizing the dominant norm and disregarding the reality of the critical roles played in child rearing by other caregivers even when biological mothers are involved.

Practice/Research Field Principles

6. Understand That Language Can Be Used to Hurt or Heal: Diversity-informed infant mental health practice recognizes the power of language to divide or connect, denigrate or celebrate, heal or hurt. Practitioners strive to use language (including "body language," imagery, and other modes of nonverbal communication) in ways that most inclusively support infants and toddlers and their families, caregivers, and communities.

Part of the structuring of the human psyche and of the social order happens through language. Consider, for example, the long history of the use of the universal masculine in the English language, wherein a subject was by default referred to in the masculine unless specifically marked as different from/other than the masculine norm (e.g., "the infant at his mother's breast"). Despite the fact that (through hard work on the part of many people) this convention has changed such that it is no longer acceptable in scholarly discourse to use the universal masculine, many injurious linguistic practices persist, some in the form of conventions and some in the form of individual instances of expression.

For example, it is important to examine the conventions and language around disability. Linton (2006) asserted that professionals must re-look at the most basic assumption of the "nondisabled position and its privilege and power. It is not the neutral, universal position from which disabled people deviate, rather it is a category of people whose power and cultural capital keep them at the center" (p.171). The social construction of ability and disability interacts with the social construction of self and powerfully influences how people come to see themselves. Rousso (1985), a psychotherapist and an adult with a disability, wrote that an infant or young child experiences a physical disability as an inherent part of the body and self which needs appreciation, acceptance, and affirmation. The moment with the most potential for emotional trauma comes not when the child realizes there is a difference but when the child discovers that the differences are perceived by society as inferior (Rousso). The discovery of this meaning does not happen in a vacuum but is shaped by society's views and by our views as professionals. Language is a part of that perspective shaping process. Language that empowers the person rather than the condition (a child with autism rather than an autistic child) promotes well-being (Snow, 2009). Language which confuses disability with perpetual suffering, passivity, or superhuman status constricts rather than opens the possibility for full development (Linton). Perspectives on disability which imply a fix-it rather than a whole person view confuse normality with full humanness (Turnbull & Turnbull, 1986). Within this fix-it framework, the parent–infant relationship shifts from nurturance to treatment and the child's worth is reflected through progress.

As is true in any field, all of the professional and scholarly discourses that comprise infant mental health are prone to reiterating turns of phrase, structures of thought, and systems of meaning that denigrate or exclude individuals or groups in insidious ways. Diversity-informed infant mental health practice therefore attends carefully to words—written and spoken, on posters and flyers and intake forms, in articles and research protocols, in policy and public awareness campaigns—in an attempt to be affirmative and inclusive with respect to the experience of all infants, toddlers, families, and communities.

7. Support Families in Their Preferred Language: Families are best supported in facilitating infants' development and mental health when services are available in their native languages.

The National Standards on Culturally and Linguistically Appropriate Services (Office of Minority Health, n.d.) mandated that health care organizations receiving federal funding make linguistically appropriate services available to clients (Aronson Fontes, 2005). It is recommended that all agencies and practitioners, regardless of funding sources, also strive to uphold these standards. Although translation and interpretation supports are an important vehicle for combating disparities in access to infant mental health services and resources, they should always be considered to be a triage effort and a temporary measure signaling the need for expanded linguistic competence (and associated cultural attunement) in the workforce. Many core developmental and parenting issues are subtle, complex, and highly emotionally charged. Much is lost in translation when an interpreter is used or when parents are forced to speak in a language other than their native one. When services are unavailable in families' native languages, the message sent is that the services are not for them, and more broadly that their infants have not been anticipated and are not welcomed by the dominant society or its systems of care.

Linguistically appropriate service delivery is especially important in the field of infant mental health because of the central role played by language acquisition in all realms of development and the salience of the language to the meaning-making potential of caregiving relationships. Parents and caregivers draw on their own preverbal and early language-saturated caregiving experiences in tending their own children. Language develops and acquires meaning in the context of the relationships with the significant others upon whom children depend. These people in turn depended upon others as children, and through the interface with the socio-cultural, political, geographical, and historical

While an infant requires devoted caregiving in order to survive and thrive, this caregiving need not be provided by a biological mother.

conditions that influenced the adults as children a great deal of cultural knowledge is transmitted along with language acquisition.. The language or languages that were acquired in early childhood are deeply entwined with children's and adults' internalized representations of themselves and of the other people they learn languages from. These languages become integral aspects of the self experience and of the relationship with those language-specific relationships. Language therefore, is closely linked with identity and is also part of coping and defense mechanisms (Javier, 1989 cited by Madrid n.d.; Pérez-Foster, (2001, 2008)). In addition, according to Santiago-Rivera and Altarriba (2002), certain experiences seem to be intimately connected to the first language learned and cannot be "recoded" (p. 34) in another language, no matter how proficient and cognitively integrated in both languages is the bilingual individual. The notion of the "native tongue" and its centrality to the cognitive, affective, and sensorial dimensions of early experiences, underscores the importance of using therapeutic interventions that are linguistically appropriate when serving immigrant infants, parents, and communities.

8. Allocate Resources to Systems Change: Diversity and inclusion must be proactively considered in undertaking any piece of infant mental health work. Such consideration requires the allocation of resources such as time and money for this purpose and is best ensured when opportunities for reflection with colleagues and mentors as well as ongoing training and consultation opportunities are embedded in agencies, institutions, and systems of care.

Diversity-informed infant mental health practice connotes a stance as much as a focus. For example, although specific diversity issues may appear on the agenda of a staff meeting at a particular agency, diversity-informed agency culture is as much reflected in the question of who creates the agenda, what diversity qualities are embodied in staff members, or how this matches or contrasts with the diversity qualities of families served. Every infant mental health undertaking has cultural implications, although these may be either considered or ignored. Issues such as the allocation of program resources; the setting of agency priorities; and the accessibility, legibility (social as well as linguistic), and perceived salience of services are all matters that carry cultural meaning. In a society in which issues such as race, class, gender, sexual orientation, disability status, immigration status, and others are fraught with conflict and in many instances saturated with historical trauma, the chances are that if diversity issues are not addressed deliberately they will be played out covertly in ways that may replicate injurious patterns in society at large or reproduce historical injustices. For these reasons best practice entails the proactive dedication of time and financial resources for planning and reflection regarding diversity issues.

Because these matters tend to be emotionally fraught for individuals as well as for groups, it is critical that every infant mental health practitioner have predictable access to a colleague or mentor with whom to deeply consider personal meanings of diversity issues. One of the gifts of the field of infant mental health to the wider professional world is an understanding of the importance of the on-going cultivation of a reflective stance as a matter of continued professional development. A paradigm shift has occurred, for example, in many mental health and social service disciplines away from purely administrative or educative supervision and toward reflective supervision. Because of the deep roots in this practice, infant mental health practitioners have contributed substantially to this evolution. It is clear to infant mental health practitioners that a caregiver's capacity for reflection, and specifically for "holding the baby in mind", is a key factor in determining the quality of the caregiver–child relationship and shaping the child's own developing capacity for thinking, feeling, and relating. The field of infant mental health has also long recognized the power of parallel process—how mutually influencing the parent–child and the practitioner–family relationships often are. A commitment to making space for consistent personal reflection is grounded in respect for these powerful processes. Building on this insight and commitment to personal reflection, diversity-informed infant mental health programs, agencies, and systems dedicate resources to providing on-going opportunities on individual and group levels for genuine engagement with the social justice issues on which infant mental health depends.

9. Make Space and Open Pathways for Diverse Professionals: Infant mental health workforces will be most dynamic and effective when culturally diverse individuals have access to a wide range of roles, disciplines, and modes of practice and influence.

Dominant structures of power and forces of oppression have long conspired to systematically limit the access of people of color and other minority groups including persons with disabilities to white collar and high status professions and to positions of influence in trades, institutions, and systems. The National Research Council and Institute of Medicine (2000) noted that "significant cultural distance between providers and recipients of health and human services can make it difficult to build and sustain the kinds of relationships that often determine the short-term acceptability and ultimate success of an early childhood intervention or family support program" (p. 66). Such cultural distance furthermore serves to reproduce injurious divisions within the social order that construct certain groups of people as ill, ignorant, or lacking while other groups are elevated to the status of healers, educators, and purveyors of resources. In the words of Banerjee Brown (2007), "Privilege and discrimination are made possible because of one another" (p. 19).

In order to counter this historical and contemporary reality, infant mental health agencies, systems of care, and training programs must proactively recruit and promote people of color and representatives of other minority groups not only into the field, but into positions of leadership. This is not possible unless individuals are prepared to recognize and relinquish the unearned power or status that constitutes privilege (McIntosh, 2002). The recognition that one may have unwittingly long benefited from racism and other forms of oppression is painful and requires significant personal reflective work that must be supported at a systems level by consistently available diversity-informed reflective consultation, supervision, or mentorship. Such consultation, supervision, or mentorship is likewise essential for those "swimming upstream" to assume leadership positions contrary to historical and contemporary trends, as personal issues such as internalized racism, or homophobia, and survival (or "thrival") guilt may, without ongoing support, impede individual success and hence hold back progress in the field and harm infants, toddlers, and families.

Broader Advocacy

10. Advance Policy That Supports All Families: Diversity-informed infant mental health practitioners, regardless of professional affiliation, seek to understand the impact of

social policies and programs on diverse infants and toddlers and to advance a just policy agenda for and with families.

Professionals in the field of infant mental health play an integral role in the lives of families. Regardless of professional status, infant mental health practitioners advocate for families within their settings and in formal and informal policy and advocacy efforts. When advocating on behalf of families, diversity-informed infant mental health practitioners are conscious not to impose their own values on clients, but to instead understand the experience and self-definition of the infant, family, or community, and consider how the proposed policy or advocacy will impact family and community life. This disciplined consideration of the experience of the other requires ongoing personal reflection about one's own individual experience, as well as an understanding of the role of racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression, as discussed in relation to Tenet #1. Tenet #10 holds that such personal and professional reflection must also be translated into action at the policy level on whatever small or large scale is possible in keeping with the resources of the practitioner, program, or system of care.

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FROM TENET TO PRACTICE

Putting Diversity-Informed Services Into Action

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The Diversity-Informed Infant Mental Health Tenets, created by members of the Irving Harris Foundation Professional Development Network, provide guiding principles for the infant mental health field to address some of the racial, ethnic, socioeconomic, and other inequities in our society (see St. John, Thomas, & Noroña with the Irving Harris Foundation Professional Development Network Tenets Working Group, this issue, p. 13, for a full discussion of the Tenets). The following vignettes will be used to provide examples of how the Tenets can guide practice when working with young children and families.

MARCUS, JUSTIN, TIA, ANITA, AND JAMES

Marcus, 50 months old; Justin, 31 months old; and Tia, 13 months old, were placed in kinship care after their mother, Anita, 24 years old, called the police to report an incidence of domestic violence. When the police arrived, they determined that Marcus had witnessed his mother and her boyfriend, James (Tia's dad) fighting. There had been other reports of domestic violence. James was arrested and would no longer be in the home, but the investigating social worker decided to remove the children from Anita's care because of her failure to protect him. Nine months later, although Anita has complied with all aspects of her reunification plan, she and her children have yet to be reunified. The social worker has told Anita that, unless she separates from James, she will not get her children back. Anita says she is not with James, but she notes that the court has given James visits with the children. Anita, James, and all the children are African American.

CLARA, SUSANA, AND MARISOL

Clara, 28 months old, was recently diagnosed with mild autism. Her mother, Susana, 29 years old, was born and raised in the United States but speaks predominantly Spanish. She grew up in Texas near the Mexican border and now resides in Arizona. Both her parents were immigrants from Guatemala. As a single mother, she works long hours so she can provide for Clara; her other daughter, Marisol, 12 years old; and family members in Guatemala. Both medical and child care providers have made numerous referrals for Clara, but Susana does not follow through. They note that when they ask if they can help, she says only God can help, and she is praying that he will give her strength.

SAMMY, JOSH, AND DAVID

Sammy was recently placed with Josh and David in the hopes that they might become his adoptive parents. Although Sammy is 30 months old, this is his fourth placement. He has significant speech and language delays; he gorges himself on food; and he walks up to strangers, especially women, and asks to be picked up. Sammy is Latino. Josh and David are White.

Abstract

The Diversity-Informed Infant Mental Health Tenets provide guidelines for addressing inequities in American society. Embedding the Tenets into infant mental health systems requires intentionality and careful consideration. With the use of vignettes, this article examines each Tenet and how infant mental health practitioners, agencies, and systems can begin to incorporate the Tenets into their daily practice.

LUZ, TERESA, AND PAOLO

Luz, 44 months old, and her parents, Teresa and Paolo, are undocumented immigrants who left Mexico after a home invasion and robbery in which Luz's older brother was killed. Luz has missed many days at preschool because of a persistent stomachache. Her mother says that, on school days, Luz refuses to leave the house, cries inconsolably, clings to her mother, and says she's in pain. She has been seen by several different specialists, and no organic cause has been identified for her pain. A day care consultant has begun to work with Luz and her mother. During one meeting, the consultant said to Luz that she knows many children whose tummy hurts when they are scared. Luz got on her mother's lap and began to cry. "Qué te pasa Luz, qué te pasa?" ("What is happening Luz, what is happening?") her mother asked. Luz replied, "No quiero que la migra te lleve" ("I don't want 'la migra' [immigration] to take you away"). Luz's father is not sure he wants Luz to be in school. He feels she should stay home with her mother. He thinks Teresa has put her in day care so she can work, and he is not in favor of Teresa working.

KYLIE, KAYLA, AND GRANDMA NAT

Kylie was born premature, approximately 29 weeks gestational age, through an emergency C-section. She was intubated and remained in the hospital for 1 month. She was then released to her mother, Kayla. Kayla is 16 years old. She reportedly used drugs (methamphetamines, marijuana, and alcohol) during the first trimester of her pregnancy, but she says she has been clean since then. Kayla and Kylie reside with Kayla's maternal grandmother, Natalie. Grandma Nat does little with Kylie. She says that Kylie is Kayla's baby and her charge to raise. Grandma Nat is very religious. She believes that if Kayla prays hard, God will show her the way, both in sobriety and motherhood. At Kylie's 4-month pediatric visit, the doctor became concerned because Kylie was seriously underweight. Kayla had also missed some of the pediatric visits. The pediatrician sent a nurse to the home. The nurse observed that Kylie kicked and struggled as Kayla tried to feed her. Kayla looked distant, and Natalie refused to step in and help. Kylie, Kayla, and Grandma Nat are White. Grandma Nat is originally from Memphis, Tennessee.

All infant mental health practitioners work with children like Marcus, Justin, Tia, Clara, Sammy, Luz, and Kylie. These practitioners may have different roles (e.g., direct service, supervision, administration, policy, or research) and different disciplines (e.g., mental health, early education, child care, home visiting, nursing, occupational therapy, child welfare), but the Tenets have important practice implications for them all. If they believe in the Tenets and choose to adopt them, they will need to think about whether what they currently do is consistent with the Tenets and other social justice values. Practitioners will need to consider changes they have to make to more closely adhere to these principles, and they will need time and support as they attempt to integrate the Tenets into their daily work.

Implementing the Diversity-Informed Infant Mental Health Tenets

Below are examples of how each Tenet acts as a beacon, guiding all of us in the infant mental health field and highlighting the challenges that might be faced and addressed in working with young children and their families. We hope that reflecting on the work in this way helps each of us begin to think about how to translate aspirations for "cultural competence" and a desire to eliminate racial and socioeconomic disparities that are so often found in all systems (Snowden & Yamada, 2005; U.S. Public Health Service, 2000) into real changes in practice.

1. SELF-AWARENESS LEADS TO BETTER SERVICES FOR FAMILIES

Professionals in the field of infant mental health must reflect on their own culture, personal values, and beliefs, and on the impact racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression have had on their lives in order to provide diversity-informed, culturally attuned services on behalf of infants, toddlers, and their families.

Working with families like the ones described earlier, Tenet #1 brings reminders of the importance of acknowledging and confronting biases that might affect a practitioner's interactions and decisions. Marcus' mother, Anita, is a young African American woman with three children from two different partners. Her current partner, James, is a young African American man with a record for being violent. They are individuals, yet they evoke racist stereotypes of lower income African Americans. Might these stereotypes, held by individuals and embedded in systems, be contributing to the protracted separation between Anita and her children? Anita was initially resistant to receiving the multiple services she was mandated to complete. Had her providers responded to her initial hostile affect and categorized her using stereotypes, she may not have completed her reunification plan. Instead, they listened to her, validated her perspective, and were able to engage her in services.

Each of the families described may bring up feelings for us as practitioners because of the challenges they face and what they represent. We may have a reaction to working with Luz and her parents because they are undocumented immigrants and we may have concerns about them utilizing U.S. resources and tax dollars. We may be frustrated with Susana. She was raised in the United States but doesn't speak much English. We might have feelings about whether Josh and David, two gay men, should be able to adopt a child or we might have a reaction as to whether they, as White men, should raise an ethnic minority child. Kayla is White, but she is not safe from bias. Many would view her as an unfit teen mother, a former substance abuser who is incapable of providing adequate care to a fragile infant.

How often do any of us in the infant mental health field seriously consider our potential biases and reflect on how they affect our work? Neurobiological research has shown that human's brains are hardwired to respond to people who are different from ourselves and to make instant associations and assumptions (Devine, 1989; Kubota, Banaji, & Phelps, 2012). As practitioners, we might try to banish certain thoughts, recognizing them as ugly, but we need to recognize that we are aware of stereotypes that are held in American culture even when they are inconsistent with our beliefs. What is less helpful is to give in to stereotypes, not challenge them, and fail to see the individuals and recognize their struggles. As we work with caregivers like those described in the vignettes, many of us as practitioners will need to recognize that we were fortunate to grow up with some forms of privilege and that this may have allowed us to make different choices than the caregivers with whom we work. If we craft interventions, design policy, or conduct research, thinking that these come from science or clinical experience and are therefore value neutral, we may see that we have unintentionally introduced our biases where we least wanted to do so.

2. CHAMPION CHILDREN'S RIGHTS GLOBALLY

Infants are citizens of the world. It is the responsibility of the global community to support parents, families, and local communities in welcoming, protecting, and nurturing them.

Tenet #2 is a reminder that, regardless of an individual practitioner's personal values, the field recognizes that the first 5 years of life are critical to the healthy development of all children, and as practitioners we do all that we can to support them and their families. Luz's distress is no less

important because she is an undocumented immigrant. In fact, it is important to recognize that when young children or their family members are labeled and treated as "illegal," this presents numerous risks for their cognitive and socioemotional development (Gonzales, 2011; Potochnick & Perreira, 2010; Suárez-Orozco, Yoshikawa, Teranashi, & Suárez Orozco, 2011; Yoshikawa & Kali, 2011). Approximately 1.8 million children belong to what has been called the 1.5 generation (Gonzales, 2007). These children, like Luz, arrived at an early age to the United States, tend to be bicultural and predominantly fluent in English, and often have little attachment to their home country (Immigration Policy Center, 2011). Because of their immigration status, their lives are restricted and uncertain, and their "dreams are deferred" (Gonzales, 2007, 2011). Legal status does not determine need for services. Although it may be difficult, as infant mental health practitioners, we are committed to providing services to those in need, regardless of partisan politics and policies.

3. WORK TO ACKNOWLEDGE PRIVILEGE AND COMBAT DISCRIMINATION

Discriminatory policies and practices that harm adults harm the infants in their care. Privilege constitutes injustice. Diversity-informed infant mental health professionals work to acknowledge privilege and to combat racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression within themselves, their practices, and their fields.

As described in Tenet #1, work to combat discrimination begins within each person. If we as practitioners find ourselves wondering whether Josh and David can be good parents to Sammy, we must understand how bias may be affecting our view. Do we see Josh and David as caregivers and not just as gay men or White men? Can we recognize their strengths? In what ways are the men connected to Sammy, and is he connected to them? Why might it be in Sammy's best interests to have them as parents, even if some practitioners may hold the opinion that they do not represent ideal parents? We do not want to make decisions based solely on race or sexual orientation; these are not the factors that determine whether a person is a good caregiver for a particular child.

The Tenets guide practitioners to be aware of potential discrimination in service sectors and address it. As practitioners we might inquire as to why Anita is still not reunified with her children given that she has complied with her reunification plan. We might wonder whether there are relevant facts we may not know or whether the decision is influenced by the fact that she fits a specific profile associated with risk. If this profile is based predominantly on external factors (e.g. race, socioeconomic status, the neighborhood where she lives), we will need to recognize that the profile, while potentially associated with risk, is also one that is likely to lead to discrimination both on a person-to-person level and on a systemic level.

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Families may have different belief structures and different ways in which they believe healing occurs.

4. RECOGNIZE AND RESPECT NONDOMINANT BODIES OF KNOWLEDGE

Diversity-informed infant mental health practice recognizes nondominant ways of knowing, bodies of knowledge, sources of strength, and routes to healing within diverse families and communities.

The families being served may have different belief structures and different ways in which they believe healing occurs. For example, David and Josh have different ways of parenting Sammy. They tend to engage in more physical rough play and have different strategies for helping Sammy when he gets hurt. When Sammy skins his knee, David uses a baseball metaphor: "You're safe," he calls out. When Sammy points at his knee, David smiles and says, "You're tough. Tough guys get up." Sammy, in turn, responds by dusting himself off. It may seem odd or unusual to consider that two White men have nondominant bodies of knowledge, but as the infant mental health field becomes increasingly female dominated, we and all its members will need to ensure that we are aware of our own biases and remain open to a male perspective.

Clara's mother, Susana, believes that only prayer and God can help with Clara's autism. As practitioners, we may not share her beliefs, but we need to recognize the incredible comfort and strength Susana derives from them. Through God, she finds the patience to parent Clara. She finds the strength to work long hours and then return home to interact with her children. Practitioners may support her in her beliefs because her beliefs offer her support and may also encourage her to become part of a church community and to visit with a priest to see how to help Clara. Beyond her religious beliefs, Susana may have other nondominant beliefs about autism. She was raised in the United States, but her parents are Guatemalan Mayans, and she grew up in a rural area near the Texas–Mexico border. It will be important to think about how her family and her community understand what it means that Clara has "autism." In her community, how are children with behaviors of this type typically seen and helped? Are there aspects of her culture that might be protective and could be integrated into medical or therapeutic treatment?

5. HONOR DIVERSE FAMILY STRUCTURES

Families define who they are comprised of and how they are structured; no particular family constellation or organization is inherently optimal compared to any other. Diversity-informed infant mental health practice recognizes and strives to counter the historical bias toward idealizing (and conversely blaming) biological mothers as primary caregivers while overlooking the critical child-rearing contributions of other parents and caregivers including fathers, second mothers, foster parents, kin and felt family, early care and educational providers, and others.

Of the families described earlier, only one—Luz's family—has a nuclear family structure. Susana is a single mother, and

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It is not the structure of the family that determines whether the child will thrive but the quality of the relationships.

her 12-year-old daughter, Marisol, serves as both Clara's big sister and a key caregiver. Marisol picks Clara up from day care and spends 3 hours caring for her until her mother returns from work. Susana wonders if Marisol could bring Clara to her appointments, get information from providers, and then pass it along to her. How do we as practitioners feel about a 12-year-old assuming the role of a key caregiver? It is the reality of their lives. Kylie, Kayla, and Grandma Nat are a family. Grandma Nat does not involve herself in Kylie's care, but she nevertheless plays a key role in the family, advising and teaching Kayla about her responsibilities. When a service provider works with the family, it is critical that they respect and engage Grandma Nat. Josh and David are Sammy's fathers. Sammy seeks out women, in part, because his biological mother abandoned him. Even if he were placed in a family with a heterosexual nuclear family structure, he would have to make meaning of this experience. Josh and David are more than capable of nurturing him and helping him as he expresses how difficult it is to have lost his mother. Anita and James both want to be involved in their children's lives. They are ex-boyfriend and ex-girlfriend and don't know if they want to be together, but they would like to be able to make this decision rather than have the courts or the child protective service system unilaterally determine their family structure. How do we as practitioners consider safety and simultaneously honor the parents' ability to make their own choices? Diversity-informed practitioners understand each family's right to determine both who is considered part of the family and their different roles. We understand that it is not the structure of the family that determines whether the child will thrive but the quality of the relationships.

Besides the caregivers described in the vignettes, Marcus, Justin, Sammy, Luz, and Clara all have day care providers who are partners in helping them develop. Any intervention with Clara will be strengthened if it involves both her family and her day care providers. Luz, Marcus, Justin, and Sammy's day care providers can provide them with better support if their parents feel safe enough to openly share their experience with them. Josh and David shared that they are two gay men raising a boy. They told the day care that Sammy was abandoned by his mother, has had multiple placements, and worries about being left. They want him to be able to have positive relationships with women. Sammy's teacher, Miss T., offers Sammy a different experience with women. She plays a critical role in shaping Sammy's beliefs about whether he can be loved and cared for by women. Josh and David recognize her importance and have asked her to babysit for them even after Sammy leaves her center. She is now part of their extended family.

6. UNDERSTAND THAT LANGUAGE CAN BE USED TO HURT OR HEAL

Diversity-informed infant mental health practice recognizes the power of language to divide or connect, denigrate or celebrate, hurt or heal. Practitioners strive to use language (including "body language," imagery, and other modes of nonverbal communication) in ways that most inclusively support infants and toddlers and their families, caregivers, and communities.

Verbal and written communications convey information beyond words, including power and social status and one's implicit beliefs. What is not said or written as well as how we as practitioners say or display things often affects families, despite our best intentions. As adoptive fathers, Josh and David have noted that many of the forms they needed to sign—to get Sammy an individualized education plan, at the speech therapist's office, and as participants in a research study on adoption—had lines for the mother's and father's signatures. The forms they fill out remind them that their relationship is unacknowledged and even rejected by many in society. Kayla and Grandma Nat talk a lot about their former providers and the way the providers talked to them. Although they all spoke English, there were differences in the language that they used. There was the educated nurse who explained everything using technical terms. She made Kayla feel dumb. Kayla felt she was supposed to understand things, and so she just smiled and nodded even when she didn't understand. There was the "uppity" occupational therapist who came to the house. She only came once. Grandma Nat said she wasn't going to have anyone in her house who looked down her nose at them. Kayla noted, "It wasn't what she said, but the way she said it." Then there was Ariel, the second home visiting nurse. Ariel said that the medical terms were hard to understand for her, too. She talked in clear, simple language and even drew pictures to explain how Kylie's body worked. It seemed hard to think that she and the first nurse were saying the same thing. She called Grandma Nat by her last name, which Grandma Nat liked because it showed that Ariel had good Southern manners and knew how to respect her elders. Marisol, Teresa, and Paolo shared how confused they felt when they received forms and handouts in English. Although they wanted services, they didn't know what to do with all these papers they could not understand, and they felt that perhaps the services were not really for people "like them." The papers sent an unintended message of exclusion and negatively affected these families' engagement with services.

7. SUPPORT FAMILIES IN THEIR PREFERRED LANGUAGE

Families are best supported in facilitating infants' development and mental health when services are available in their native languages.

Tenet #7 clearly highlights the need for bilingual service providers when working with a monolingual non-English-speaking

family, but it also suggests the need to consider language when working with bilingual families. Clara's day care worked hard to integrate services for her. She was initially working with an English-speaking developmental specialist, but the day care staff advocated for her to change to a Spanish-speaking provider. They wanted to support her interactions and language development in Spanish, as this is the primary language of her home. It might be hard for the family if she progressed in English but was not able to connect in the same way in Spanish. Moreover, the Spanish-speaking provider could communicate better with her mother, Susana. Susana speaks fair English, but her emotional language is clearly Spanish, and when she is trying to help Clara and working through her feelings about Clara's autism, it is hard for her to share all that she is going through in English.

8. ALLOCATE RESOURCES TO SYSTEMS CHANGE

Diversity and inclusion must be proactively considered in undertaking any piece of infant mental health work. Such consideration requires the allocation of resources such as time and money for this purpose and is best ensured when opportunities for reflection with colleagues and mentors as well as ongoing training or consultation opportunities are embedded in agencies, institutions, and systems of care.

Many of the aforementioned examples present the careful thought and time it takes us as practitioners to become aware of our biases, craft service plans, conduct research, or set policies that consider diversity. Sammy's speech therapist heard Josh and David's remarks. She recycled her old forms and made changes because she wanted to eliminate the bias she now saw. It was a small but important change, despite the cost of new forms. Clara's day care providers were able to hold a meeting in Spanish, where they met with the developmental specialist and the mother and discussed the different options for Clara's treatment. They talked about how they each felt about Clara's getting services in English or Spanish and developed a plan, recognizing that it might change as Clara became older and would transition to an English-only school. Marcus, Justin, and Tia's social worker obtained consultation from an outside consultant. They jointly and openly talked about how the family's race affected the worker's perception of safety. It took considerable time, safety, and allocation of resources for this conversation to take place, but it resulted in a shift in practice. These small shifts that reflect justice and inclusion can deepen connections and provide a higher level of service for families.

The work of enhancing diversity-informed practice is the work of a team, not of a few members of the team who perhaps are ethnic minorities.

9. MAKE SPACE AND OPEN PATHWAYS FOR DIVERSE PROFESSIONALS

Infant mental health workforces will be most dynamic and effective when culturally diverse individuals have access to a wide range of roles, disciplines, and modes of practice and influence.

The work of enhancing diversity-informed practice is the work of a team, not of a few members of the team who perhaps are ethnic minorities. Luz's child care consultant, Andrea, typically has a higher caseload because there are more Spanish-speaking families in need of services. She believes that the families she serves require more case time because of immigration-related stress and fears related to their legal status and that this affects both their ability to use services and her stress as she works with them. Andrea's new agency seems different from the one she recently left. They recognize the need to hire and train more Spanish-speaking practitioners and are mentoring Andrea to serve as a leader. During case conferences, practitioners of all ethnicities actively talk about how the family's immigration status and cultural beliefs affect the work; she is not the lone voice highlighting diversity-related factors. As the agency works to be more inclusive, many practitioners have begun to recognize the tremendous privilege they enjoy and have started talking about how their assumptions about service delivery may not apply to those who have not shared a similar upbringing. They have also become more consciously aware of other communities they have not served as effectively. They are in an area that serves a large Vietnamese immigrant population. They are beginning to think about how they can recruit, train, and learn in partnership with Vietnamese staff to serve that population better. They understand that, as they do this, their agency and practitioners will likely need to change and grow. Andrea's current agency serves as an example of a diversity-informed system. They increase their capacity to effectively serve diverse populations by actively considering how diversity affects their work and by training, hiring, and mentoring staff from the underrepresented communities that they serve.

10. ADVANCE POLICY THAT SUPPORTS ALL FAMILIES

Diversity-informed infant mental health practitioners, regardless of professional affiliation, seek to understand the impact of social policies and programs on diverse infants and toddlers and to advance a just policy agenda for and with families.

The ZERO TO THREE Policy Center motto is "I am a big voice for little kids" (zerotothree.org). As we and other practitioners identify discriminatory policies that harm young children and their families, we will need to raise our voice against these policies. For example, as can be seen with Luz, current policies around the deportation of immigrants have negative consequences for their children's development. Although individuals may have differing political views related to undocumented immigrants, policies allowing caregivers to be rounded up, detained, and sent back to their country—often without any ability to let their children know what has happened (Wessler, 2012)—are in opposition to the core values of the infant mental health field. This type of separation is traumatic to a young child, can negatively affect the child's development, and may lead to the need for costly services in the future. Moreover, practitioners might reflect on whether all undocumented immigrant families are treated this way through policy or procedure. Do similar things happen to families from France, England, or India who remain in the U.S. without visas, or is this much more common with lower income, Latino immigrants?

As practitioners, when we work with families like Anita and James, we may need to recognize that these are young, lower income African American caregivers who feel that they have little power or privilege to confront the immense power of the child welfare system that may perpetuate the historic systemic separation of African American families in the United States. How will we as practitioners lend our voices as advocates to the parents' struggle to stay together as a family? How will we as practitioners remain mindful of safety but develop service plans that give the family the best chance of healing from violence? How might we as practitioners use our experience to work toward changing policy? We might consider partnering with others to develop policies that help child welfare workers better understand the effect of historical trauma on African American families and help them develop service plans that can be used to reunite families with histories of domestic violence if those family members decide they want to be together. Using a diversity-informed lens, practitioners can strive to create policies that

ensure equal treatment regardless of race or socioeconomic status.

It is not easy to confront the aspect of human nature that leads an individual to embrace some groups and exclude others, but engaging in this struggle is key to the core values of the infant mental health field. We hope that the Tenets help us and all professionals in the infant mental health field clearly see pathways for change that move us toward diversity-informed practice.

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Broadening the Scope

Next Steps in Reflective Supervision Training

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Abstract

As the infant mental health workforce expands to meet the needs of increasingly diverse families and communities, leaders of the work—most often, supervisors in community settings—should be responsive to and reflective of the ethnic or cultural backgrounds of those served. The Reflective Supervision Training Program described addresses an important concern about the lack of supervisors from underrepresented communities of color in agencies that serve predominately non-White, and often monolingual or bilingual clients. The authors describe the impact that this program has had on participants and on their own understanding of the needs of supervisors working in diverse communities.

Reflective supervision is considered a foundational element for infant and early childhood programs (Eggbeer, Mann, & Seibel, 2007). In this article, we aim to open dialogues at the local, regional, and national levels about the possibilities and importance of including an increased focus on diversity and social justice in reflective supervision in the multidisciplinary infant mental health field. Throughout the article, we refer to the Diversity-Informed Infant Mental Health Tenets (St. John, Thomas, & Noroña, with Irving Harris Foundation Professional Development Network Tenets Working Group, this issue, p. 13).

Supervisory Dilemmas

The vignette highlighted presents a set of clinical dilemmas faced by a supervisee and her supervisor in an urban home visiting program. In discussing this vignette, we will refer to some of the emerging literature that supports integration of the more robust concepts of diversity and social justice. Next, we describe a supervisory training program developed through The Irving B. Harris Early Childhood Mental Health Training Program at Children's Hospital & Research Center Oakland that is designed to both increase the number of supervisors of color and develop more understanding about how faculty members can hold diversity and social justice in mind as they prepare supervisors from all backgrounds.

The Supervisee

Julia is a bicultural/bilingual Portuguese-English clinician who works at a community mental health program that serves children and families exposed to traumatic events. About 40% of the referrals to the program come from recently immigrated monolingual Portuguese or Cape Verdean Creole-speaking families, many of whom are unauthorized immigrants. Julia was an intern in the agency and was offered a job after she graduated from her master's program. She has worked in her position for 1 year and is the only clinician in the agency who can speak fluent Portuguese; her caseload is usually large, and her clients require a significant amount of case management and advocacy. Recently, Julia has been feeling extremely tired and, at times, hopeless as she faces many roadblocks in helping her clients meet their basic needs (i.e., shelter and food) and identifying additional mental health treatment for them (i.e., adult mental health and stabilization services). In addition, she feels that in the agency, there is no acknowledgment of the fact that she has more cases than her colleagues and that her cases often bring additional

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Small-group seminars included chances to discuss, as a group, how race, class, and culture played out in supervision and training groups.

challenges. Julia believes that her supervisor, Sarah, is knowledgeable and reliable; however, Sarah focuses on overseeing Julia's paperwork, monitoring her productivity, and reviewing her casework, so there is little room to discuss how Julia is doing. Moreover, Julia has not brought up any of her concerns to her supervisor because she is afraid that she will be perceived as unqualified for the job or inefficient. She is a second-generation immigrant herself, and she grew up listening to the accounts of hardship that her parents—asylees from Angola who moved to the United States—faced, in their jobs and in other areas of life. Their experiences motivated Julia to work with immigrant families, but now she is having second thoughts. The stories of her client families are affecting Julia to the point that she is losing sleep. She has also begun to fall behind in her paperwork, and although she made a plan with her supervisor to update her clients' charts, she has not been able to comply with this plan, which is making her feel guilty.

The Supervisor

Sarah is a young Caucasian social worker who has been with the agency for 3 years and who, 2 years ago, begun supervising students and staff. Sarah was extremely excited when she found out that Julia was going to be her supervisee. Julia came with excellent recommendations from her field supervisor and advisor; she was described as "highly motivated, hardworking, and insightful." In addition, Sarah has an interest in working cross-culturally, and although she had not supervised any bilingual staff members previously, she thought that working with Julia would be a mutually enriching experience.

Sarah is concerned about Julia and about their supervisory relationship. She is aware that there is only time to do follow-up on Julia's casework. She has attempted to explore how Julia is feeling about her numerous and complicated cases; however, Julia always replies, "No worries; I can handle it," or "If we don't see these families, who is going to see them? They will probably go on a never-ending waitlist somewhere else." The many challenges that Julia's clients present have made Sarah feel inadequate at times: Often, she does not have answers to support Julia in addressing her client's needs, in terms of resources or immigration issues, and she knows that it is hard for Julia to translate the content of her client sessions from Portuguese into English in order to receive supervision. Sarah sees Julia as the expert in some aspects of the work—she speaks the families' language and is skilled at identifying community networks to help her clients. Although she has noticed that Julia seems unmotivated and distracted, Sarah has avoided bringing this up in supervision because she is concerned that Julia may perceive her as being judgmental. In past conversations, Julia had shared with Sarah how her parents were discriminated against at their workplaces for belonging to a minority group. Therefore, Sarah has instead focused on supporting Julia in catching up with her paperwork, but Sarah's suggestions are not working, and Julia is becoming increasingly distant and quiet.

Considering the Tenets

This vignette illustrates the importance of the Diversity-Informed Infant Mental Health Tenets' aspirational principles regarding antidiscriminatory practices and policies (see Tenet #3 and #9, St. John et al., this issue, p. 13). The vignette also illustrates that even though an organization may be staffed with well-trained, diverse employees serving a diverse population of clients, often this may not be enough to build a diversity-informed infant mental health agency. More intentional efforts will be needed to promote the development and provide support for an ethnically, culturally, and linguistically diverse workforce to serve the needs of an increasingly diverse population in the United States. Tenets #3 and #9 provide reminders that when combating discrimination at the institutional and professional levels, staff members and supervisors should pay careful attention to (a) avoiding and eradicating prescribed organizational arrangements, such as the one in the vignette above, that, despite the best of intentions, reproduce aspects of the forces of oppression that operate in society at large and can generate problematic patterns in the of division of labor and (b) creating or integrating organizational supports to ensure that workers from minority groups not only have access to "diversity-informed reflective consultation, supervision, or mentorship", but [also] that they are promoted into supervisory and leadership positions (St. John et al., p. 13).

Julia feels isolated and burned out, and she cannot communicate her feelings; thus, she may be at risk for secondary traumatic stress—and for losing her job. Staff members in these kinds of settings need well-trained supervisors who understand the complexity of service needs—supervisors who can see that a staff person's ethnic background, immigration legacy, and linguistic abilities are assets that must be understood and supported more mindfully. Julia's supervisor, Sarah, has been neither prepared nor supported, organizationally, to provide the kind of guidance that would nurture and protect Julia in her role. It is unfortunate that this bright young woman who is so dedicated to serving her community is becoming increasingly alienated and ineffective.

The vignette also underscores the intricacy of identifying the needs of students and staff who are providing bilingual services. Being a bilingual trainee or worker may represent a benefit during the recruitment process for a job or internship; nevertheless, it can become a burden once the person is in the field or on the job, and it can lead to burnout and high turnover (Delgado-Romero, Espino, Werther, & González, 2011).

Individuals who represent minority status groups frequently:

1. Serve large numbers of vulnerable ethnic and linguistically minority clients.
2. Face the challenges involved in transferring learning in one language to clinical work in another language.
3. Translate the themes of their clinical work into English to receive supervision.
4. Educate colleagues and supervisors about diversity issues and the needs of minority families.
5. Handle additional job responsibilities (e.g., interpreting, translating documents, advocating) when compared with English-speaking workers.
6. Experience less promotions and opportunities for advancement into supervisory or leadership positions.
7. Experience consequent feelings of emotional exhaustion, exploitation, and isolation.

(Castaño, Biever, González, & Anderson, 2007; Delgado-Romero et al. 2011; Verdinelli & Biever, 2009).

The Diversity-Informed Infant Mental Health Tenets #6 and #7 (St. John et al., this issue, p. 13) describing cultural and linguistic competence at the practice level are relevant here. The expectation that a worker or trainee should translate the content of sessions, home visits, and field work into English evidences an "ethnocentric view that all issues can be easily described in English and understood by someone who is not familiar with important contextual and cultural issues, such as family structures, cultural values, and religious practices" (Schwartz, Domenech-Rodriguez, Santiago-Rivera, Arredondo, & Field, 2010, p. 212). Increasing awareness of the role of language and "how emotions are represented in language and encoded in memory" (Schwartz et al., 2010, p. 16) has implications for supervising or serving members of linguistic minorities. (e.g., words connoting emotion can be represented differently in different languages or have no translation into English). The vignette illustrates that there are potential legal and ethical concerns as well and that it is crucial that organizations support monolingual supervisors to take responsibility for addressing cultural and language matters with their supervisees; it should not be assumed that bilingual and minority supervisees are experts in diversity. Being bilingual or skilled in a language other than English does not make an individual's practice culturally responsive or diversity-informed (Schwartz et al., 2010; Santiago-Rivera & Altarriba, 2000; Verdinelli & Biever; 2000).

> A staff person's ethnic background, immigration legacy, and linguistic abilities are assets that must be understood and supported mindfully.

Julia and Sarah's story is not unique. Dilemmas such as those illustrated in the vignette led to creation of the Reflective Facilitators in Training Program, which is described below.

The Reflective Facilitators in Training Program

The Irving B. Harris Early Childhood Mental Health Training Program at Children's Hospital & Research Center Oakland (hereafter, "the Harris Program") is part of the Harris Professional Development Network (PDN). The program has a strong commitment to the core concepts of diversity and social justice embodied in the Diversity-Informed Infant Mental Health Tenets, and Program adminstrators and staff have worked diligently to engage practitioners from diverse backgrounds into the Harris Program's infant mental health training programs. The program embraces reflective practice and aims to help participants develop leadership as well as clinical skills and knowledge. Tenet #1, "Self-Awareness Leads to Better Services for Families," informs the heart of this work which is to help professionals develop a deeper understanding of their own beliefs and cultural values so these can become useful tools in their clinical practice.

One primary goal of the Harris Program is to increase the number of supervisors and leaders in local agencies with expertise in infant mental health. Several years ago, as part of a review of the Harris Program, program staff looked at how many graduates had moved into supervisory positions. We discovered that there were fewer graduates of color who had moved into supervisory jobs. This caused great concern because it is important that agency staff demographics reflect the clients they serve. Most agencies in the Oakland area serve African American, Latino, Asian, and/or first-generation immigrants. Reasons for the lack of graduates of color who move into supervisory jobs were unclear, and the Harris Program staff wondered what might be accomplished if these graduates were recruited into a program that offered high-quality reflective supervision training infused with considerations of how culture, class, context, and difference inform the supervisory process. The Reflective Facilitators in Training (RFIT) Program provides opportunities for infant mental health practitioners of color to receive diversity-informed supervision and leadership training that would help them move into supervisory and leadership positions. The second goal of the Harris Program is to build more understanding of how to bring knowledge about diversity and social justice into supervision training.

RFIT is a 2-year training program that reflects some of the emerging research about supervision, program implementation, and diversity. The research in bilingual supervision indicates the importance of supervising staff in their native languages because this deepens the quality of care provided. Research on program implementation (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005) and emerging studies on reflective supervision show the value of strong support and a reflective supervisory stance for clinicians, home visitors, and others working with infants, young children, and families. In addition, research findings reveal that, from the worker's perspective, serving young children and families is complex. For workers, supporting families' psychological well-being unavoidably awakens intricate feelings and reactions (Steinberg & Kraemer, 2010). Although all of the abovementioned research is important to the infant mental health field, Harris Program administrators and staff knew less about the implications of this research for supervisors of color or for those learning to become supervisors. We wanted to infuse principles of diversity and social justice into all of our supervision training and become more responsive to the needs of supervisors of color and others working with multicultural populations .

Key activities of the RFIT program include:

- Conducting diversity-informed training in reflective supervision and group facilitation.
- Participating with Harris Program staff as co-facilitators in various learning groups in the Harris cohort trainings.
- Participating in bimonthly individual supervision with a Harris trainee, including supervision in Spanish.
- Providing mentoring for the RFIT trainee related to the group facilitation and supervision.
- Observing and videotaping the RFIT trainees' work in facilitation or supervision.

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It is important to invest in building skilled leaders who are able put a clear voice to the complex dynamics of race, culture, and difference.

- Supporting trainees to build a rich repertoire of supervisory skills through discussion of their own supervisory and facilitation work—in particular, how various issues related to diversity and social justice influence these processes.

The RFIT curriculum is aligned with the reflective facilitation/supervision competencies in California's *Revised Training Guidelines and Personnel Competencies in Infant Family and Early Childhood Mental Health* (California Infant Family and Early Childhood Mental Health Training Guidelines Workgroup, 2009). Graduates of our program meet requirements for endorsement in this system as reflective facilitators, an opportunity that can open doors for them to move up into new roles as supervisors and facilitators.

The RFIT Program is structured with dyadic training, a small-group seminar, and observation. The small-group seminar emphasizes developing a safe environment that encourages exploration of diverse views. As stated in Tenet #6, we wanted to help trainees and staff put words to these ideas and practice "the power of language to express, to hurt, or to heal" (St. John et al., this issue, p. 15). RFIT trainees read not only from the rich literature of reflective supervision but also from readings on social justice and cross-cultural communication. Curriculum design emphasizes cultural and contextual responsiveness rather than cultural competence or knowledge, per se. This emphasis in supervisory training builds self-awareness, deepens and enlivens supervisory experiences, and expands participants' abilities to participate in an open dialogue with those providing services in the richly complicated human geography of the RFIT Program service area. The program provides knowledge of how individuals adapt to change in the process of immigration and migration; instruction on the ways in which historical injustices can continue to shape lives; a focus on how culture, class, and context shape development; awareness of privilege; and exploration of how values about differences shape not only programs but also communities and regions. In the small-group training, we have helped participants understand the difference between intent and impact and to be comfortable talking about both. It has been our hope that this kind of approach in training and program settings ultimately prepares practitioners to be more effective at creating safety and opening a dialogue in any setting.

The RFIT Program administrators intentionally recruited a diverse cohort of trainees to reflect the mission of the program. Participants in the first group included two African American women, a Latino man, two Latina women, a Filipina woman, and a Chinese American woman. Five of the participants were born outside the United States. Two facilitators—one Caucasian woman and one Latina woman—developed and facilitated the group. Other Harris Program staff members served as mentors to each participant, and, as possible, the mentors conducted the sessions in the RFIT participants' native language. Supervision done by the trainees was also provided in the supervisee's native language, when possible. Small-group seminars included chances to discuss, as a group, how race, class, and culture played out in supervision and training groups and what approaches supported more open discussions. We introduced vignettes and exercises to engage participants in discussing dilemmas, and we provided trainees with many opportunities to discuss how their own backgrounds affected facilitation and supervision. Currently, a second training group is in process. This group is smaller, all women, and includes one Caucasian bilingual trainee along and three trainees of color. All participants in this group are bilingual.

Lessons Learned

The examples that follow describe themes drawn from program learning groups and mentoring sessions and are meant to illustrate the complexity of the material that emerged during the training. Vignettes are amalgamations of conversations that provide a window into how this concentration on diversity and social justice issues melds with other supervisory training experiences. The names of the participants described below are pseudonyms that we assigned to ensure anonymity.

- Participants wondered how their own experiences and culture might shape or cloud perception of a supervisee's concerns or clinical judgment. Were they able to hold and help sort out complex material when the situations brought to them were close to, or diametrically opposed to, their own experiences? For example, April's own experience as an immigrant often brought up painful memories of feeling marginalized and excluded. She found herself feeling "irritated" that the person she was supervising did not seem pick up on or empathize enough with the perspective of her client, who was an immigrant. April worried that memories of her own experiences were driving her to see the world exclusively through this lens. In the RFIT seminar, she explored her irritation and ways to monitor her own reactions so that she was careful with questions, remarks, and suggestions that she offered to her supervisee.
- Participants noted that they felt perplexed, at times, when supervisees or group members saw their cultural identity first and their supervisory skills second. They noted that sometimes, a supervisee seemed to worry that the supervisor would feel insulted if a client from the same background as the supervisor was discussed in a way that might be perceived as negative. Chantelle

noted that participants in her mental health consultation group often did not divulge the racial or cultural background of a child who was being discussed. With her seminar group, she explored why this was not named and how she could bring this omission to the group's attention in a way that was not perceived as belligerent or distracting.

- Participants wondered how to expand conversations about cultural difference to help supervisees see a client's individuality. Patrice observed that one of her supervisees tended to overidentify with clients whose background was similar to her own. Patrice, whose background was different, worried about being accused of insensitivity and not "understanding" the situation if she addressed her observations too directly. With the help of her RFIT learning group, she began to enlarge her understanding of the situation and find language to help the supervisee see her clients' complexity and uniqueness.
- Participants worried about how to address negative assumptions about a particular cultural or ethnic group, gender, or individual that were seemingly unconscious or not noticed by an individual or group. Would raising the issue lead the supervisee to be afraid of making a mistake? How could these issues be addressed in useful ways, particularly at times when they might be offensive to the supervisor? Caroline cringed at a slightly derogatory remark about a same-sex couple that was made in a reflective practice group that she was facilitating. She asked herself if she should just let it go or if addressing this remark would benefit the group. She evaluated whether this was all about her own sensitivities: Where did the two overlap? She froze in the moment and said nothing, but she found that her abilities to facilitate were affected by her annoyance. She wondered if the energy in the group was lagging because of her feelings or if others were also having similar reactions but were not speaking. A thorough discussion in her mentoring session helped her find words and ways for the next time that this kind of remark surfaced.
- Participants grappled with how to handle situations in training groups that reflected real conflicts in communities served. Portia described how she had sensed the tension in her group as one of the participants wrestled with how to respond to parents who were afraid of going to a particular resource center for specialized services because someone from the family's background had been seriously injured in the neighborhood. In a parallel fashion, the group member was uncomfortable in the discussion because Portia was from the same group that the participant's clients feared. Portia described to her mentor how she had noticed the participant's discomfort and desire not to offend. Portia went on to share how she had tentatively named the dilemmas both in the group and in the community. This discussion with the mentor opened up the topic of how to support staff whose clients were new to the area and who were afraid of individuals from different cultural and ethnic backgrounds. The discussion helped Portia continue and expand rich dialogues with her supervisory group, and these discussions helped staff members open up rich dialogue with their clients about these painful topics.

The RFIT program transformed the Harris Program's work because it made the program, overall, more aware of the needs of professionals of color in the field of infant mental health. All staff members involved learned a great deal about how to better teach and support supervisors in training, and they learned more about how complicated it can be for individuals of color to move into leadership positions. It is important to invest in building skilled leaders who are able put a clear voice to the complex dynamics of race, culture, and difference. Supporting these leaders provides opportunities to enrich training, supervision, and other group processes because of the individual's skills in observing and discussing complex dynamic situations. Having supervisors able to supervise in the supervisee's service delivery language has proven to be effective because it allows access to emotional resources and also develops and enriches intervention capacities. Graduates of the program are all currently providing some form of supervision or facilitation in the community—and, often, not in English. The Harris Program staff is skilled in reflective supervision. However, the staff learned new skills about providing diversity-informed reflective supervision as well as providing a training program that reflects the values of diversity and social justice. One goal of the RFIT program is to build a cohort of supervisors who can sustain some of the learning within their own agencies and larger community.

Discussions over the years in the Harris PDN meetings raised many questions about diversity and social justice and how these concepts are factored into program development and training. In piloting this program, we were able to learn more about the legacies of discrimination in our community and the ways in which opportunities for practitioners of color have been limited. We learned additional ways to approach topics of race, class, privilege, and other differences. We also learned more about what happens when these topics are constricted.

Emerging studies on reflective supervision show the value of strong support and a reflective supervisory stance for clinicians, home visitors, and others working with infants, young children, and families.

Clearly, a program of such limited size and scope cannot influence an entire field—or even a region—with only anecdotal evidence. Next steps will include a more sophisticated evaluation of the program's impact on participants and on the agencies where they work and a subsequent revision of materials as well as the program model for our next cohort. The Diversity-Informed Infant Mental Health Tenets (St. John et al., this issue, p. 13) will be a guide to further inform and stimulate our work in this area. We hope that this brief description and examples from the process learning group and mentoring sessions will provide more understanding of the need to have diversity-informed supervisory training. Over time, we hope to continue to increase supervisory skills that promote awareness, comfort, and the ability to create safe environments for practitioners of color to discuss the strengths and challenges of their roles as supervisors and leaders. And we hope that the Julias and the Sarahs of the infant mental health world will benefit from even more enriched models of reflective supervision training.

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Creating and Sustaining an Interdisciplinary Infant Mental Health Workforce

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More now than ever, infant mental health (IMH) professionals recognize both the remarkable capacities and deep vulnerabilities of young children and their families, and they appreciate the power of early relationships and experiences to have long-lasting impacts. This knowledge base is informed by biological, psychological, interpersonal, and cultural perspectives on children, families, and development (cf. print and video resources at Harvard University's Center for the Developing Child, National Scientific Council on the Developing Child, 2008, 2010a, 2010b), and new IMH professionals must have some understanding of these perspectives. Consequently, developing a sustainable, competent IMH workforce is an urgent and challenging task for the field. Numerous authors have addressed the complexities of doing so (Eggbeer, Mann, & Gilkerson, 2003; Finello, 2005; Frankel & Harmon, 2000; Hinshaw-Fuselier, Zeanah, & Larrieu, 2009; Pawl, St. John, & Pekarsky, 2000; Zeanah, Larrieu, & Zeanah, 2000; ZERO TO THREE, 2011). What makes IMH professional development (PD) so powerful is also what makes it so challenging: the multiple demands of cultivating providers from diverse backgrounds and systems, and cultivating a relationship-based, culturally and developmentally sensitive, and responsive and reflective approach (see the Diversity Informed Mental Health Tenets, St. John, Thomas, & Noroña, with the Irving Harris Foundation Professional Development Network Tenets Working Group, this issue, p. 13; Noroña, Heffron, Grunstein, & Nalo, this issue, p. 29). This article will examine common features of PD initiatives and key questions that have guided IMH PD efforts in the Harris Professional Development Network (PDN), to provide a framework for planning new initiatives to support the expanding IMH workforce and for reviewing ongoing efforts.

Workforce PD, often labeled "training" for brevity, includes preprofessional and ongoing in-service experiences in training, mentoring, and both self-guided and collaborative group learning. Several programs have developed IMH PD models that include these

Abstract

Developing a sustainable, competent workforce is an urgent and challenging task for the infant mental health (IMH) field. In this article, the authors share their experiences and perspectives on the importance of and challenges in the development of the IMH workforce. The broad view of both workforce members and professional development experiences provides ideas for readers from many disciplines. This article summarizes key questions and general challenges in both professional development and the translation of training to practice. The authors discuss specific considerations regarding the unique issues in distance-learning strategies for the field and identify future steps to advance the quality and evidence base for IMH professional development.

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The power of early relationships and experiences has long-lasting impacts.

experiences, all of which share the following foundational elements:

1. Relationship-based approach
2. Interdisciplinary perspective
3. Consideration of cultural and individual diversity
4. Developmental orientation
5. Emphasis on reflection

Because of the vulnerabilities and trauma histories of many of the families served by IMH providers, PD models must also integrate trauma-informed perspectives into IMH services. (See box, A Trainee's Voice, #1, for a thoughtful integration of the foundational elements from the experience and perspective of an IMH trainee.)

Key Questions About PD

The roots of IMH are theoretically rich and diverse. More than 50 years ago, "Fraiberg constructed a new service model that integrated systems theory, classical and contemporary psychoanalytic theory, and the field of genetic epistemology" (Fitzgerald, Weatherston, & Mann, 2011, p. 178). Among the first IMH PD efforts, in 1973 Fraiberg trained an interdisciplinary group of practitioners with diverse levels of experience, from student to established professional, in community mental health agencies in Michigan (Fitzgerald & Barton, 2000). Her service model transcended the typical approaches to clinical practice and engaged parents and their infants where they lived (Fraiberg, Adelson, & Shapiro, 1975, used the phrase "psychotherapy in the kitchen"). Since its inception, the organizational leadership of ZERO TO THREE has included interdisciplinary perspectives and promoted cross-disciplinary collaboration. ZERO TO THREE's support for the IMH leadership workforce has included fellowship programs for professionals from many disciplines over several decades. In addition, state and local and public and private programs across the country—that vary in intensity, duration, and focus regarding their IMH workforce initiatives—have proliferated. To organize the following section describing the scope of IMH PD, three key questions will be addressed: Who? What? and How?

Who Is the IMH Workforce?

The IMH workforce includes virtually everyone invested in prenatal, infant, or early childhood development. As such, it includes traditional mental health service providers, supervisors, and consultants, as well as primary care providers and educators, whose activities are not typically considered "mental health." Further, the IMH workforce includes those who are not involved in direct practice but whose efforts support practice and program innovation, such as policy makers, philanthropists, researchers, public administrators, and educators in institutes of higher learning. Within the IMH field, there have been some systematic attempts to develop frameworks that have been helpful in guiding PD for multiple professional audiences (California Infant-Family and Early Childhood Mental Health Training Guidelines Workgroup, 2009; Center for Prevention and Early Intervention Policy at Florida State University, 2001, 2008; Costa, 2006; Michigan Association for Infant Mental Health [MI-AIMH], 2002, 2011; see also Weatherston & Paradis, 2011). Although these frameworks have unique features, one common strategy has been to distinguish among training audiences who differ in type or level of IMH work. For example, Florida's plan has three levels of provider (frontline provider, early interventionist, clinician), whereas Michigan's plan has four levels (associate, Level I specialist, Level II specialist, and mentor; the latter includes clinical, policy, and research leaders).

In addition to acknowledging different levels of IMH work, IMH PD takes specialized approaches for different trainees and contexts (e.g., early child care, home visiting; see Powers, 2011). IMH workforce expansion must also consider diversity among trainees, families, and settings (Finello, Hampton &

A Trainee's Voice, #1

As an IMH trainee, I spent my first home visit session staring at the Confederate flag hanging in my client's living room, angry that I had to serve this person. At our last session, I hugged her as she handed me a cap that she had knitted for my soon-to-be-born baby. The reflective supervision provided by my IMH program gave me a framework that highlighted the best in this family, and what I brought, as a woman of color, to this situation. I listened to the advice she gave me on being a first-time parent. I learned the importance of humility, wondering, and being an expert in not knowing. Instead of teaching didactics on time outs and point systems, I heard her. I gave this woman an opportunity to think about how her history colored the way she acted with her children. This experience shaped the way I now interact with my clients—regardless of the clinical hat I am wearing. Before this program, I had some evidence-based strategies in my bag of tricks—but something was missing. I found a home in IMH. Here we focus on who people are, and how their backgrounds shape them. Diversity is not just tolerated, or fitted into a pass/fail course, but embraced. I did not need to critique the graduate students I supervised or parents into being better at what they did. Instead I could embrace what was good, and give these caretakers the confidence and skills they needed to do their difficult job.

Table 1: Levels, Services, and Providers in the Infant Mental Health Field

Level of Service/Population	Typical Services	Examples of Professionals
Universal: Aim is prevention and early intervention; services considered low intensity and available to all, regardless of "risk."	Health supervision; developmental screening/ surveillance; education and promotion; child care/ early education: early identification and referral	Primary health care: physicians, registered nurses, social workers, psychologists, developmental specialists; early child care and education: teachers, paraprofessional aides, peer counselors/support
Targeted/Selective: Aimed at prevention and early intervention for vulnerable, "at risk," or those with early signs of problems; services are of higher intensity and frequency.	Risk-specific assessments and prevention; home visiting; specific early intervention; child protection/foster care	Registered nurses, occupational therapists, speech therapists, physical therapists, social workers, paraprofessional or lay support, early care and education professionals, foster parents, legal advocates
Treatment: Aimed at those with significantly impaired development, health, or relationships; most intensive of services, requires highly specialized skills.	Diagnosis and treatment, including psychotherapy, medications, or other mental health services	Licensed mental health professionals (social workers, counselors, psychologists, psychiatrists)
Systems and Policy: Scope may be at agency, local, state, or national level.	Advocacy, legislation, financing, policy development, and systems collaboration and coordination	Administrators, legislators, lawyers, policy makers, advocates, families and consumers

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Poulsen, 2011). Table 1 illustrates a framework that identifies IMH levels, services, and/or providers. The right-hand column indicates the wide range of "who" may be part of IMH PD audiences.

What Should Be Included in PD?

The extensive list of services in the middle column of Table 1 shows wide variation in IMH service types and implies numerous service settings. Nevertheless, a central goal of IMH PD is to bring a consistent viewpoint to all trainees that reflects the IMH foundational elements (see the list on p. 36). This viewpoint then informs the trainees' professional perspective and skills as applied in diverse services and settings. Historically, these elements may have been easily infused into some types of professional preparation programs; however, IMH PD programs must expand to ensure all participants develop shared IMH understandings and practices that are adapted to their individual disciplines.

Larger themes also influence the work of IMH and must be incorporated into PD. IMH professionals might think of these themes as "lenses" that affect all they see, do, and understand. For example, the trauma perspective, including awareness of the impact of trauma experiences on caregiving and child development and utilization of trauma-informed approaches to assessment and treatment, is now considered foundational knowledge and skills for all who work with young children and their families, regardless of their primary discipline, program focus, or work setting (Layne et al., 2011; Lieberman & Van Horn, 2008; Osofsky, 2011).

The Diversity-Informed Infant Mental Health Tenets (St. John et al., this issue, p. 13) also provide a set of lenses to be incorporated into the "what," or contents, of IMH PD. Specific examples include (a) the "recognition of nondominant bodies of knowledge" (Tenet #4) as professionals develop awareness and appreciation of families' views of sources of strength and strategies for healing, and (b) considerations of "language," for example, what language is used as well as how language is used (noted in Tenets #5, #6, and #7). As programs use "classic" materials (e.g., texts, video materials), professionals must consider how they may (or may not) convey the inclusive stance embraced in the Tenets, may under- or overrepresent some groups, or may fail to communicate subtleties of meaning that do not translate across languages. How best to use some of the foundational IMH materials should be approached with these considerations in mind.

In part to systematize IMH PD training contents and outcomes, some in the field have made considerable efforts to develop competency and credentialing systems (Korfmacher & Hilado, 2010). A widely used certification process is Michigan's endorsement system (MI-AIMH, 2002, 2011), which followed from 25 years of experience of practice (Weatherston, Kaplan-Estrin, & Goldberg, 2009) and is now used in 13 additional states. Similarly, a dedicated work group in California recently completed a 10-year project to create the California Infant-Family and Early Childhood Mental Health Training Guidelines Workgroup (California Infant-Family and Early Childhood Mental Health, Training Guidelines Workgroup, 2009). Both systems provide readers with comprehensive information regarding important PD content for domains of knowledge and practice and critical PD experiences that must be incorporated into training efforts.

Because the material of IMH is often emotionally evocative and value-laden, participants may respond regarding both their personal and professional experiences. It is not unusual for learners to grasp material quite differently the first time they are exposed to it as compared to later, when they have clinical experience in which to place the information into context. Often, the phenomena of interest are not new, but they may be viewed differently through the IMH perspective (e.g., teaching parents how to feed their infant vs. appreciation of infant feeding as a way to understand, or even enter, the parent–infant relationship). Recognizing how everyday, moment-to-moment interactions reveal important information about the parent–child experience can be powerful, often resulting in a "paradigm shift" from an individual-oriented stance to the relationship-oriented stance of IMH. IMH PD must enhance trainees' (a) awareness of the complexity of the individual family's culture, (b) understanding of how personal

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Developing a sustainable, competent infant mental health workforce is an urgent and challenging task for the field.

and cultural experiences shape the beliefs and expectations of all family members, and (c) capacity to translate therapeutic interventions into diverse cultures in a sensitive manner.

Appreciating the extensive nature of the IMH knowledge base, as well as acknowledging (and tolerating) when or what practitioners do not know, are cornerstones of the field, and PD must assist in developing practitioners' comfort with this aspect of their work. Ethical practice demands that practitioners be clear about the purpose of their work; the scope, including legal, ethical, and practical limitations, of their IMH training and skills; and the availability of service-related resources (Hinshaw-Fusilier et al., 2009). The absence of a single code of ethics to govern the multiple disciplines in the IMH workforce complicates supporting adherence to a common code of conduct. Although overall IMH PD goals in the field include infusion of IMH concepts and practices in all work with young children and families, not all IMH PD content is appropriate nor necessary for all workforce members.

How Should PD Be Delivered?

Early on, IMH PD within the PDN stayed local to each site or state. Some advantages of local university- and community-based models include availability of expertise and the building of local networks of IMH colleagues that develop capacity and collaboration within and across agencies, whereas disadvantages include a financial burden for those who attend from other locations and difficulties with scheduling and getting work-release time. In recent years, PDN PD models have been adapted in response to the need for expanded capacity and broader geographic reach, as well as for more flexibility in time and location (e.g., to allow students to continue their current work simultaneously or maintain other responsibilities). Examples are multisite PDN collaborations, such as the expansion of the Fussy Baby Network (Gilkerson, Gray, & Mork, 2005) from the Erikson Institute in Illinois to multiple programs in six states, and the growth of distance-learning opportunities. PDN sites have done some transitioning beyond face-to-face IMH PD to models that include both face-to-face and multiple distance IMH PD features (e.g., conference calls, teleconferencing, and webinars, and other online models such as hybrid distance course models used in higher education). For example, PDN members in California and Louisiana have developed learning collaborative models with the National Child Traumatic Stress Network to expand capacity to deliver Child–Parent Psychotherapy for young children and families who have experienced trauma (Van Horn et al., this issue, p. 48).

Translating PD Into Practice

Although what happens in IMH PD is important, the providers of that training must also be concerned with what happens after in terms of leadership, sustainability, and fidelity to IMH practices and models. Multiple challenges arise when trainees leave a program and attempt to translate IMH principles back into early childhood systems. There are costs as well as benefits for those who go back and try to make change. Often frontline practitioners who choose to remain within these systems are stymied when it comes to bringing these IMH elements into their practice. Given that problem, how do trainers ensure that the investments made in PD translate to more effective services and better outcomes for children and families? We consider this question in regard to each of the IMH elements: relationship-based approach, interdisciplinary perspective, consideration of diversity, developmental orientation, and emphasis on reflection.

Relationship-Based Approach

This element can be complex for trainees as they attempt to "translate" their training experiences into work within service delivery systems. We assume trainees thrive in the context of nurturing and supportive relationships (parallel to children and families), and the goal is for them to incorporate this emphasis on relationships into their IMH efforts. However, new ways of working with families may include strategies for initial relationship building and engagement that do not align neatly with common intake processes or procedures. Or, new skills in parent–child relationship observation, assessment, and intervention may not fit easily into typical documentation or billing requirements. Supportive and respectful relationships among colleagues and between colleagues and supervisors may be difficult to establish in settings that rely on contracted employees who work primarily off-site. Taken together, even when systems desire to embrace IMH, there may be strains for both IMH graduates and their colleagues and supervisors as they create new collaborative working relationships. IMH PD programs must be intentional about anticipating the challenges that a trainee might encounter and offering guidance to help trainees bring IMH ideas and practices into systems so that they feel heard and effective, while tolerating the developmental process of the system's adaptation to IMH concepts and practices.

Interdisciplinary Perspective

As families and relationships become the focus of support and intervention, the need for expertise in addressing both children's and adults' vulnerabilities becomes more apparent (Finello et al., 2011). IMH trainees come to the field with varying backgrounds in adult or child mental health. However, when families' needs exceed the providers' professional capacities or specializations, IMH PD programs and service provider systems must be prepared to identify and adapt strategies to best support and protect both the family and provider. IMH PD must

also support trainees to reflect upon their own limitations in terms of practice and, when needed, encourage them to connect families with additional providers. For some families, adding or shifting to other providers may be a significant challenge. Underlying this shift, then, must be the reassurance that the work of IMH is very much still happening, as often it is only the trusted primary provider, being particularly sensitive to a family's readiness for auxiliary services, who can facilitate this process . Consequently, interdisciplinary reflective supervision models are needed to best appreciate strengths and limitations in all areas of IMH practice.

The need for an interdisciplinary perspective also informs the issue of how best to create leaders for the field at large. In addition to efforts such as the PDN and ZERO TO THREE's programs, the Michigan competency framework (MI-AIMH, 2002, 2011) has also included guidelines for systems, advocacy, and mentoring expertise. (See box, Special Considerations Regarding Leadership Development, for an elaboration of the issues involved in leadership development and the breadth of expertise to be addressed in IMH PD efforts.)

Consideration of Diversity

The Tenets (St. John et al., this issue, p. 13) and IMH Workforce articles in this issue provide extensive considerations of how systems must adapt in order to embrace inclusive stances regarding children, families, providers, and services. For example, Tenet #9, "make space and open pathways for diverse professionals," (p. 15) highlights the importance of proactive PD strategies to ensure that the IMH workforce becomes more diverse to reflect the families and communities being served. There is frequently a "pyramid" of diversity in many IMH PD settings as well as in service delivery systems, with the least diversity among the IMH PD faculty or the administration of a program or system, increasing diversity among the trainees and program or provider staff, and even greater diversity among the families receiving services. IMH PD efforts must work to support larger system infusion of more comprehensive considerations of diversity, as well as movement to address inequities in how services must be delivered. Success in these efforts depends on ongoing relationships and follow-up between PD and service delivery systems regarding what is planned, provided, and evaluated.

Developmental Orientation

As mentioned earlier, when trainees begin their programs, they arrive with knowledge, skills, experience, values, and expectations that impact the learning and internalization of the developmental perspective, as well as how they respond to the often evocative material in IMH PD. For example, trainees grounded in behavioral or medical model perspectives may experience more dissonance with the IMH content than trainees who have prior exposure to family systems or psychodynamic frameworks. Other factors may influence how new IMH material and ways of thinking are incorporated into clinical practice, including prior work experience in home- or clinic-based work settings; amount of experience

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Everyday, moment-to-moment interactions reveal important information about the parent–child experience.

Special Considerations Regarding Leadership Development

Much IMH PD focuses on clinical concepts and practices and places relatively less emphasis on career development for IMH faculty and trainers or IMH leaders and advocates. Many regions of the country lack mentors for emerging leaders. The field needs leadership development in a variety of areas:

- Clinical experts—"Master" clinicians as well as researchers develop the substance of IMH practice, that is, the skills, knowledge, and expertise needed to guide the field into new and evidence-based approaches. These leaders also provide mentorship for those entering and experienced in the field of IMH.
- Systems development—As a multidisciplinary field, fluency in cross-system coordination and collaboration and network development is needed (Gebhard, Jones, & Ochshorn, 2011), but such skills are not necessarily in the clinician's repertoire or tool kit. Such expertise and leadership may also come from fields of advocacy, legislation, law, government, and business. In any case, understanding IMH principles and approaches is needed to develop integrated systems to best meet the needs of infants, young children, and their families.
- Policy development—Recognition of the impact of early experience on later health and development is resulting in significant national, state, and local investment in prevention and early intervention. Translating research and clinical experience to influence policy for the benefit not only of our youngest citizens but all citizens is a rapidly growing area of activity, and it requires specialized skills and knowledge.
- IMH PD methods—Effective use of new educational technologies and platforms to ensure relationship-based sensitivity and skill is a challenge for the immediate future, and it requires innovations in planning, implementation, and evaluation to assure this large, diverse workforce grows competently.

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Professional development must enhance trainees' awareness of the complexity of the individual family's culture.

with parents, infants, and toddlers; or a personal history of trauma or family difficulty. (See box, A Trainee's Voice, #2, for a trainee's perspective on the ongoing developmental challenges of IMH PD.)

Emphasis on Reflection

Although IMH PD professionals train students about the importance of reflective practice and supervision, it is not always clear how well these tools are integrated into practice on a systems level. Establishing their permanency is complex, even within experienced mental health systems where the constructs are understood, valued, and considered cornerstones of professional competencies (Heller & Gilkerson, 2009). Especially in settings that serve some of the most vulnerable and complex families, diminished time and resources can interfere with implementation of reflective supervision. When settings include multiple disciplines or have a far wider range of prior IMH PD among providers, the reflective supervision expertise may not be available. In addition, senior administrators in systems frequently are not familiar or experienced with the concepts of reflective supervision. Consequently, they may not invest in establishing or maintaining the structure necessary to support it, particularly when there are other needs competing for tight budgets. In any case, when support for reflective supervision is lacking, it can become difficult to retain frontline providers who struggle to manage and contain this emotionally difficult work (Eggbeer, Mann, & Seibel, 2007). Ideally begun early in one's PD, reflective supervision may also be an essential tool for promoting self-awareness and more sensitive diversity-informed services as both the workforce and families served reflect expanded cultures, backgrounds, experiences, languages, and beliefs (see Tenet #1, "self-awareness leads to better services for families"; St. John et al., this issue, p. 13).

Learn More

The Harris Network at ZERO TO THREE. P. Glink (2004). *The Harris Network, 1,* 1–10.

Translating Relationship-Based Approaches to Distance Learning

Given the urgent need to train a wide range and number of IMH professionals, the traditional approach of face-to-face interactions between PD instructors and trainees can be limiting, cumbersome, time-consuming, and expensive. Thus, there is great impetus to transfer at least parts of IMH PD into distance- or online-learning platforms. However, inherent to IMH PD is creating a safe learning milieu that contains and uses the emotions the material can stir up and also cultivates the development of relationships with, and among, trainees. These relationships are critical in fostering a healthy "parallel process"; that is, the reflective support trainees receive and provide for each other during training is then mirrored in their future interactions with families. Consequently, the translation of current in-person approaches to other models is especially complex.

Use of online learning is complicated and carries both challenges and strengths (cf. Seibel, 2011, regarding the addition of effective coaching and e-learning approaches). Specifically, the challenges of creating a relationship-based learning milieu within the framework of online distance-learning environments underscore how dependent PD programs have become on using the instructor's physical presence in IMH PD (e.g., real-time responsiveness to verbal and nonverbal cues) to create reflective learning collectives.

On the other hand, PD programs using online forums as part of their course training have found they can be a better learning tool for those who need more time to process and integrate the complex material into their understanding of themselves and their work. Absorbing and integrating the readings and case examples, then crafting a written

A Trainee's Voice #2

"Baby girl, graduate school is about making students crumble so they can be reformed into the mold," the administrative assistant at my research position comforted me. I was in my second year of school and never felt more incompetent. Graduate school, thus far, highlighted my limitations.

This was before my IMH program, before parallel process, before wondering, before room to not be an expert. Honestly, specializing in IMH has not exactly simplified my studies. I've spent a lot of time being confused. The feeling reminded me of starting school in the U.S. a few years after my family immigrated to this country. How can a thought be exalted in one department, but degraded in another? How do I know when to be a behaviorist, and when to use IMH strategies? As I prepare my dissertation, I continue to grapple with these ideas, and the complexity of combining these worlds. Due in part to my new perspective, I do not fit into "the mold" in my home graduate program. This, of course, leads to more wondering.

In review of this process, I did not understand initially what this incongruence meant—or how to address it. I did not have the skills or space or words to identify what was confusing me. Next steps in IMH might include direct conversations regarding this incongruence for trainees, maybe utilizing "cultural brokers" between areas of service when they return to their non-IMH homes.

post in response to prompts and each others' posts poses different requirements to the learner than reacting to the same materials spontaneously in a face-to-face class. This format provides trainees with different types of opportunities to attend and respond to each other's comments closely. When all trainees are required to respond in a written discussion, the most reticent of voices can be heard. The nature of the material, impacting trainees personally as well as professionally, might also lend itself to more active exploration and integration because of the anonymity seemingly provided by online forums, although clearly this can provide as many challenges as it does opportunities for learning. As in live IMH PD opportunities, instructors must monitor, contain, and organize online discussions to maintain safety and regulation in the group.

In sum, the field is challenged to reconsider what professionals know, and to think flexibly, creatively, and intentionally about how the core IMH PD elements are translated into a variety of methods for learning for a range of learners. It is likely that a blend of formats would best meet the diverse needs of learners and also convey the content effectively. For instance, hybrid learning models that incorporate face-to-face experiences with distance-learning modules may help establish the foundation for the IMH PD relationships that continue throughout the distance program and beyond, as some of our preliminary experience suggests. Furthermore, although written discussion forums might be well-suited for the knowledge base sequence in IMH coursework, live virtual classrooms offer important benefits for real-time case consultation or the observation aspects of IMH PD.

Conclusion and Future Directions

Despite the array of challenges described in this article, we conclude on a hopeful note, recognizing the real advances that have been made. IMH PD has come a long way in 40 years, and it is in a stage of rapid expansion. Although we have raised more questions than answers, we suggest some important next steps:

BUILD AN EVIDENCE BASE FOR REFLECTIVE SUPERVISION.

Reflective supervision is a key element of IMH practice, and it is expensive. Administrators and policymakers need an evidence base for its effectiveness for child and family outcomes, as well as a cost–benefit analysis for systems in order to fully integrate this "best practice" into IMH PD and practice. A model for this work is mental health services research on organizational-level culture and climate and clinician-level work attitudes (Glisson et al., 2008). Current IMH PD programs could form a "research consortium" to address this issue. Results could help refine and expand the implementation of reflective supervision and consultation practices into more systems.

MEASURE THE IMPACT OF THE "WHO," "WHAT," AND "HOW" OF IMH PD.

We believe that it is important to, whenever possible, train supervisors and staff together for at least key parts of the IMH PD, to facilitate the implementation and mastery of new practices in work and system settings. The inclusion of program graduates in subsequent IMH efforts can help extend mastery; build capacity and leadership; and expand diversity in training, mentoring, and supervision. In order to sustain and justify IMH PD programs, and to develop and evolve "best practices," trainers need to continue to evaluate and quantify not only how various training approaches impact the individual's practice but also how system needs are addressed. Qualitative and quantitative methods can help assess shifts in ways of being and applied practice at individual, interdisciplinary team, and system levels.

SHARE COMPETENCY FRAMEWORKS.

It is important to consider mentoring for IMH PD programs. Many PDN sites have benefited from each others' support and mentorship. This is an important time for the sharing of competency frameworks and the identification of foundational knowledge and practice that can be useful to new IMH PD initiatives and prevent the reinvention of some wheels. This can also be helpful when initiatives have limits in time, resources, or expertise in order to decide how to focus their first efforts for maximum success.

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An Attachment-Based Home Visiting Program for Distressed Mothers of Young Infants

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To help mothers cope with the challenges of early parenting, the Israel-based home visiting project Mom2Mom was founded in the year 2000. The project works to provide ongoing support and guidance to new mothers; connect them with community, health, legal, and social services as needed; and serve as advocates in family court and at proceedings that determine social benefits or custody, when required. In figurative terms, the project can be described as concentric circles of support—like virtual hugs—with the outer ring representing coordinators "holding" the volunteers in the project, the middle ring representing the volunteers holding "their moms," and finally at the center are the mothers holding their babies, taking their first steps in building their relationship. "Contained" by the virtual hugs, mothers feel stronger, more centered, and better able to fulfill the emotional and physical needs of their infants. Research shows that a mother's capacity to be emotionally available to her infant and to mindfully attend to her infant's needs promises the best start for the dyad as they begin their life together.

This article describes the Mom2Mom project and its underlying premises, the model, its organizational processes, initiatives beyond home visiting, challenges and limitations, and directions for the future. The Irving Harris Foundation and the Professional Development Network (PDN) are central supports in these endeavors. In the containment model of concentric circles of support, the Harris Foundation and the PDN take respectful positions on the outermost, fourth, circle embracing the program so that the program can embrace mothers, so that mothers can embrace their babies.

Premises: Attachment Theory

Mom2Mom is based on *attachment theory*, which holds as a fundamental principle that trust and caring are the foundation of secure relationships (Bowlby, 1979; Cassidy & Shaver, 2008). These are the kind of relationships that all of us depend on and that make us feel well taken care of, loved, and appreciated. In turn, within these relationships, we feel good about ourselves, are able to express feelings openly, think clearly, and take better care of ourselves and others. Consistent with these ideas, research studies show that for parents, emotional support from a person they trust promotes sensitive parental behavior and

Abstract

Mom2Mom is an attachment-based home visiting project for distressed mothers of young infants, based in Israel. Home visitors, who are volunteer mothers from the community, are trained and supervised by professionals. Home visits occur weekly for 1–2 hours and continue until the infant is 1 year old. The project was founded in Jerusalem in year 2000 and now has 16 branches throughout Israel and one in Australia. The establishment of Mom2Mom in multiple and diverse communities, as well as empirical data derived from evaluations, indicate that the project has merit as a community-based intervention project for families with young infants.

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Trust and caring are the foundation of secure relationships.

mindful caregiving of their young children (Isabella, 1994). Research also shows that parents who feel well supported are less likely to develop depression and anxiety (Stapleton et al., 2012) that can have detrimental effects on parental behavior and perceptions (Lovejoy, Graczyk, O'Hare, & Neuman, 2000) and profound negative influences on children's physical and mental health (Field, 2011; Kaitz & Maytal, 2005). Scholars agree that supporting mothers through the challenges of the postpartum period is an effective means of promoting children's healthy development (Lillas & Turnbull, 2009).

The Model: Partnering With New Mothers

On the basis of attachment theory, Mom2Mom offers mothers of young infants a source of emotional support—a partner who will be there through the ups and downs that often accompany the birth of a new baby. Home visits are 1–2 hours, weekly, and continue until the infant is 1 year old. Volunteers can ease mothers' challenges by serving as trustworthy and dependable sources of support. By modeling, encouraging open discussions, and sharing in the delights and challenges of early parenting, volunteers help mothers adopt realistic expectations, find effective techniques to manage stress, focus on and recognize infant cues, and regulate infants' state and emotions. Often by just being there, volunteers can help reduce mothers' fears and anxiety, alleviate feelings of aloneness, and allow the free expression of feelings and concern, which can lead to strategies and solutions. Volunteers and mothers can share delight in the infant's development.

The home is a good setting for intervention with families. In the case of Mom2Mom, home visiting allows the volunteers to see the family at work and at play on its own turf and to see firsthand some of the issues impacting the family. Home visiting also affords volunteers opportunities to model sensitive caregiving and safe practices in the home. It is important to note that home visiting makes it possible for intervention efforts to reach women who might have difficulty getting to groups or to individual treatment sessions outside of the home. It also may be easier for mothers to discuss intimate topics and share personal information in a familiar context; and this may hasten the process of relationship building, which is the crux of Mom2Mom.

The mothers (more than 600 to date) who have joined this Jerusalem-based project over the years are diverse (see Table 1). Some are self-referred, and some are referred by professionals in the community. Some mothers have issues that are common to many mothers; others come to the project with special challenges, which need special consideration. The list of examples is long and includes adolescent mothers who come from abusive homes and women with sensory or cognitive impairment, physical challenges, difficult childhood histories, problematic family relationships, mental health issues, or infants or partners with special needs. For all of the mothers in the program, visits with their volunteer provide an opportunity to express difficulties and concerns, strategize, consider solutions, and plan for the future. It is a "place" where mothers can feel like "regular" mothers, accepted, validated, and appreciated, regardless of where they came from or what their issues are.

Volunteers in Mom2Mom are caring individuals who want to help a family with a new infant get off to a good start. Volunteers do not adopt the role of teacher, clinician, or problem-solver; rather they are partners, confidantes, listeners, and nonjudgmental sources of caring and support. In this spirit, the content of home visits is not predetermined; there is no curriculum per se. Volunteers and mothers shape the visits to meet the mothers' needs and circumstances. Sometimes it takes time for volunteers and mothers to find the "dance" that feels good to both "partners"; sometimes the dyad enjoys "love at first sight." However, in all cases, we believe that a trustworthy partner who is a mother herself and who is there for the selfless purpose of helping another woman through the challenges of early motherhood is a wonderful gift for women trying their best at the most important job in the world: being a parent.

Processes

Although emotional at its core and without strong confines or rules, Mom2Mom depends on well-honed and efficient processes. These include advertising and outreach, referral, and engagement

Table 1. Presenting Issues of Mothers in the Project

Issue	% of mothers in the program
Single, divorced, widowed	22.8
Very low income	33.2
Isolated/new immigrant	45.2
Mother has physical disabilities	9.8
Mother has mental health issues	20.1
Infant health issues	12.0
Marital issues	26.8
Pre- or postnatal complications	22.2

Note: ($N = 376$); mothers may present with more than one issue.

with families, as well as training and supervision. Once a family is referred to the program, a four-step enrollment-process is initiated: (a) a coordinator visits the mother in her home to answer questions about the project, assess needs, and consider a fitting volunteer; (b) coordinators "match-make" at weekly staff meetings, based on schedules, places of residence, life experiences, personalities, belief systems, languages, and other factors; (c) there is an exchange of names and contact information; and (d) home visiting begins.

Volunteers are trained at 1–3 month intervals in groups of 6 to 10. Training is 8 hours, divided into 2-hour sessions, usually scheduled on 4 successive weeks. The content of the training session is highly interactive and includes role playing and thought-provoking exercises that help volunteers understand their role, feel the spirit of the project, and practice relationship-building skills such as active listening. Perhaps most important, the training sessions allow volunteers to experience firsthand the bond that develops between individuals as they share and work together. Training is fun, and volunteers report that the training has positive effects on their own parenting and family relationships.

Each volunteer attends group supervision monthly, although in many cases, private supervision and sometimes daily contact between a volunteer and a coordinator is needed if a family is in crisis or in transition. In such cases, social workers and other professionals or resources may be called in to help. Sometimes emergencies arise; therefore, at least one coordinator is reachable 24 hours a day, 7 days a week.

Evaluation is an integral part of the Mom2Mom protocol, and both volunteers and mothers are asked to answer a series of questions (orally or in written form) about mothers' gains from the project and their appraisals of the quality and depth of the relationship forged with the volunteer, as well as the quality of the overall project. A sample of results is shown in Table 2.

Beyond Home Visiting: The PDN, Networking, Replication, and Integration

The PDN has been masterful in showing its members the importance of dependable, ongoing, real connections between like-minded professionals for sharing challenges, learning, and support. As an example, discussions at PDN meetings have encouraged us at Mom2Mom to consider fathers as partners in the home visiting process, and this has helped change the program's response to fathers who are present at intake or during visits. Also, the PDN's discussions of microaggressions—hints of prejudice and bias that can creep unconsciously into a person's behavior and words (Sue, 2010)—have increased our awareness of ingrained biases, and this important topic has been incorporated into Mom2Mom's training sessions. The PDN also has taught us a great deal about advocating at the national level for infants and toddlers. This has been very helpful in efforts to promote national pre- and postpartum screening of mothers for depression.

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Supporting mothers through the challenges of the postpartum period is an effective means of promoting children's healthy development

In the spirit of the Irving Harris Foundation, Mom2Mom has partnered with and helped individuals or groups who want to start a branch in their communities in Israel and abroad. In fact, Mom2Mom is a near replication of a U.S.-based project, Visiting Moms (Jewish & Family Services, Boston, MA), but shaped to fit our volunteers, participating moms, culture, and language. At present, there are 16 offshoots of Mom2Mom in Israel and one in Sydney, Australia. Some locations have replicated the full model of home visiting, including training, supervision, and evaluation protocols, whereas others have adjusted their own programs to be more in line with the attachment-based philosophy of Mom2Mom. The locales within Israel are diverse, including ultra-orthodox communities (Beit Shemesh), communities in the periphery of the country (Dimona, Maale Adumim), large cities (Haifa, Tel Aviv), Arab communities (Kafr Karaa), and one that is university affiliated (Beersheba), like ours. Financial support for the projects outside of Jerusalem comes from government ministries at the national (e.g., Ministry of Social Welfare, Ministry of Health) and municipal levels of government and from donations from the private sector. In all, Mom2Mom is easily replicable because the basic tenet—the importance of sensitive support—holds

Table 2. Percentage of Mothers Who Rated Items Between 3 (*yes*) and 5 (*very much so*) on a 5-Point Scale.

Item	% rated 3–5
A more positive attitude	85
Feel less isolated	89
Help in solving problems	74
Feel less anxious	60
Sensitivity to my baby	69
Appreciation of myself	80
Understanding of older children	79
Feel more comfortable with own feelings	86
Trust in others	60

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Home visiting makes it possible for intervention efforts to reach women who might have difficulty getting to groups or to individual treatment sessions outside of the home.

across people, families, subcultures, and societies. To help support professionals interested in replicating the project, we have designed an 8–12-hour training program to transmit both the spirit and practical information about the project, and we provide professional supervision to coordinators of the offshoots for as long as needed. These and all of our services are provided free of charge.

Government support (Ministry of Health) of supervision for coordinators in all branches of Mom2Mom reflects appreciation of the project beyond its borders, as does government support of several branches of Mom2Mom, particularly in poor and religious communities. The Mom2Mom playgroup offers mothers and infants a safe venue to meet other mothers from the community and to discuss problems and issues of concern. At present, we are promoting Mom2Mom as an adjunct intervention for mothers who screen positively for postpartum depression in the new national health initiative. At the level of higher learning, the Mom2Mom model has been used as a focus for seminar papers and theses. Students' participation in the project is accredited by the Department of Psychology and the School of Social Work at Hebrew University of Jerusalem. Finally, Mom2Mom is often highlighted in the Israeli media as a quality, volunteer-based community project that provides help to Israeli families. In this way, Mom2Mom serves as a model and source of encouragement to other professionals who are planning community-based projects on a small scale and limited budget.

Limitations and Challenges

Although Table 2 indicates that the Mom2Mom project is very successful for families, there are a number of challenges and limitations to the model.

Access

Some mothers do not "let us in." This could be due to mental health issues, distrust of services because of bad experiences in the past, hidden secrets within the household, general fears, or the overwhelming weight of practical matters that can disallow mothers' consideration of their own well-being and emotional needs. For these women, efforts are made to explain the project and the benefits that could be derived by joining, although in some cases the difficulties are so entrenched that best efforts are unrequited.

Trauma

Stress and threat are integral to living in Israel, and how volunteers and coordinators rise above their own fears and anxieties to meet the needs of others is not straightforward. Here, the mutual support gained from open discussions between coordinators and peer volunteers during reflective supervision sessions is essential. With that, it is important to appreciate the humanness of everyone in the project and to use common fears (and hopes) as channels to share and bond with each other.

Professional Capacity

The majority of volunteers do not have a background in dealing with families in crisis, although approximately 30% of the volunteers do; and many volunteers have life experiences that allow them to understand and empathize with the mother whom they are visiting without formal training. Nonetheless, coordinators of the project must protect the volunteers by helping them focus on their role and hold fast to boundaries that are comfortable for them and their own families. Coordinators need to be sensitive to volunteers' autonomy and yet be there for them as sensitive backup, ready to step in, if needed.

Directions for the Future

More extensive collaboration and sharing with the other branches of Mom2Mom could help build a strong coalition of individuals that would be able to lobby more effectively for families and together create new initiatives for supporting them. Combining and comparing evaluation data across branches of Mom2Mom will be important for assessing the efficacy of Mom2Mom as a model and for identifying particular design features that are more effective than others. It will be beneficial to integrate additional sources of support and guidance (e.g., lawyers, financial advisors, medical specialists, occupational therapists) into the intervention project so that a package of services can be offered to families in need. As one example, Miriam Chriki, one of the project's coordinators, was trained by Alicia Lieberman and Patricia Van Horn in Child-Parent Psychotherapy (Lieberman, Ghosh Ippen, &Van Horn, 2006), and Chriki now offers home-based short-term therapy to mothers suffering from trauma. Expansion of this line of intervention within Mom2Mom enriches and extends the care and support offered to mothers and families. We also are considering the addition of the Fussy Baby Model (Gilkerson, Gray, & Mork, 2005; Gilkerson et al., this issue, p. 59) into the Mom2Mom program, which would be a wonderful and appropriate extension of services to community-based families with young infants.

Conclusions

Mom2Mom is a viable and effective means of reaching and supporting mothers who are having difficulty coping with challenges during the first postpartum year. The establishment of Mom2Mom in multiple and diverse communities, as well as empirical data derived from evaluations, indicate that the project has merit. More generally, the successes of Mom2Mom uphold the well-supported contention that optimal growth and development occur within nurturing relationships. This project underlines the fact that this applies to adults as it does to babies.

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Miriam Chriki, *MA, is a developmental psychologist and coordinator of Mom2Mom, Hebrew University, Jerusalem, Israel. Chriki has carried out research on differences in maternal and paternal behavior during the early postpartum period and has evaluated new intervention techniques for very young children with sensory and regulation disturbances. In addition to coordinating Mom2Mom, Chriki works with young children with early signs of risk or pathology, particularly autism, and their families.*

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Replication of Child–Parent Psychotherapy in Community Settings

Models for Training

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Abstract

Child–Parent Psychotherapy (CPP), an evidence-based dyadic therapeutic intervention for very young children exposed to trauma, is becoming the go-to therapeutic intervention for infant mental health practitioners. Although CPP has been shown to be effective for rebuilding the parent–child relationship, reducing trauma symptoms, and reducing depression in mothers, there are some challenges to training and disseminating the model. The authors present two training methods that have been anecdotally effective in training clinicians in the model.

Child–Parent Psychotherapy (CPP) is an evidence-based intervention for children birth through 5 years old who experienced interpersonal trauma and their caregivers (Lieberman & Van Horn, 2005, 2008; for a summary of the empirical support for the model, see Toth, Manly, & Hathaway, 2011). Although CPP was developed and tested with diverse populations, it is a challenging intervention to replicate in community settings for a number of reasons. The main reason is that CPP is an intervention that does not have prescribed session contents or *a priori* theoretical selection criteria for interventions within sessions; therefore, it can be complicated to learn and implement. In this article, we will briefly describe the intervention, focusing on core bodies of knowledge that clinicians must master in order to learn to deliver it effectively. We will discuss two training methods that, at least anecdotally, have been used effectively to train clinicians to deliver CPP with fidelity, and we will offer detailed descriptions of these methods at work. Finally, we will discuss some of the limitations of the training methods described and offer directions for the future.

CPP: Essential Lenses and Bodies of Knowledge

CPP describes a way of thinking clinically that focuses on strengthening the protective quality of the parent–child relationship with the aim of ensuring the child's healthy social–emotional development. The child–parent psychotherapist works to strengthen a parent–child relationship potentially derailed by traumatic events by translating the child's internal world and motivations to the parent and the parent's motivations to the child. In order to be effective, the child–parent psychotherapist must possess keen observational skills and a comfortable command of several bodies of knowledge. Essential knowledge about child development, trauma theory, and cultural sensitivity provides the lenses through which the clinician views the parent–child relationship and helps her select the most effective ports of entry or opportunities for intervention.

Child Development

Attachment theory posits that protection of young, vulnerable members of a species by their stronger and wiser caregivers is a biological imperative that ensures the survival of the species (Bowlby, 1969/1982). Infants and young children rely on their caregivers to appraise risk for them and to mount appropriate responses to risk so that the children are protected from being psychologically overwhelmed, physically injured, or both. When this protective shield fails and the child or someone he loves suffers psychological trauma or physical damage, the child's developmentally appropriate expectations are shattered.

Children's real protective relationships with their attachment figures interact with their internal worries about emotional and physical safety. Whether or not they have secure attachment relationships and whether or not they experience violence, all children experience anxieties that unfold sequentially during infancy and early childhood: the fear of annihilation, the fear of loss of the parent, the fear of loss of the parent's love, the fear of damage to the body, and the fear of being bad (Freud, 1926/1959). These anxieties become all too real in situations of interpersonal violence and, combined with the undermining of the child's expectation of protection, can leave a child feeling frightened and vulnerable in situations that are not objectively dangerous. The child–parent psychotherapist's job is to translate the child's need for protection in order to help her understand, whenever possible, the parent's urge to protect, and to move the parent–child relationship toward a place of greater physical and emotional safety.

Trauma Theory

Trauma shatters fundamental assumptions that humans all hold to one degree or another: that the world is a benign place, that people are worthy of help and protection, and that other people can be counted on to be helpful (Janoff-Bulman, 1992). Trauma also makes dramatic changes in the ways a body responds to stress, priming the central nervous system to respond to sometimes objectively benign reminders as if they were dangerous (LeDoux, 1998). When children and parents are both traumatized, they may each see potential danger in situations that appear safe to the other, and they may sometimes see one another as dangerous. The child–parent psychotherapist's tasks are to normalize these responses—both the physiological distress and agitation that accompany a perceived threat and the cognitive–affective belief that danger exists in situations that are not objectively risky; to help the child and parent find ways to calm their bodies so that they can be regulated in relation to one another; to help both parent and child move toward a more realistic assessment of risk; and to create a space in which the parent and child can create a joint narrative of what happened to them, facilitating a sense of mastery and an ability to distinguish the traumatic past from the present.

Cultural Sensitivity

When the focus of intervention is on the parent–child relationship, culture is, of necessity, a companion on the therapeutic journey. The roles of parents and children in the family, as well as the relationship between the nuclear family and the extended family, are culturally determined. How the family responds to its larger context is culturally determined. The ways in which family members can seek help, and from whom, are culturally determined. In addition, families exist within broader cultural groups which may have experienced group traumas over the course of their histories (Ghosh Ippen, 2009). For all of these reasons, a child–parent psychotherapist must be open to understanding the family's history and values as the family sees them without consciously or unconsciously imposing his own values on the family. This requires that the child–parent psychotherapist be sensitive to areas of difference and humbly curious about the family's experience of difference.

In summary, CPP is a complex model in which the clinician is guided by multiple bodies of knowledge both in formulating strengths and vulnerabilities and in intervening. Replicating CPP in community settings demands training models that are sufficiently open and flexible to support clinicians in learning the theoretical material and applying it to real cases. Training models must also extend over time so that clinicians can practice their skills of formulation and intervention, get feedback on their work, and apply the feedback to their cases.

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Infants and young children rely on their caregivers to appraise risk for them.

Two Models for Training

Below we will briefly describe two such training models, and then provide three examples of how they work in a variety of settings.

The Learning Collaborative or Learning Community Model

A *learning collaborative* is a model of training with very specific features: (a) multiple teams work together to learn or improve a practice or a system learning from their collective experiences and challenges; (b) the training extends over time (with CPP, 18 months) giving the teams time to adopt effective practices that facilitate the implementation of the practice in their settings; (c) a structured learning process that includes, for CPP, three in-person trainings over a 12-month period, follow-up consultation activities on the phone or internet to support sustained learning, and opportunities to practice new skills and share progress with other teams; (d) a learning process that includes techniques that lead to accelerated improvement, including small tests of change and the collection of team metrics as an integral part of the training; (e) a learning process that involves participation by members at various levels of the organizational hierarchy on the team, providing for give-and-take on both the

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All children experience anxieties that unfold sequentially during infancy and early childhood.

clinical and the administrative practices required for implementation of a practice (Markiewicz, Ebert, Ling, Amaya-Jackson, & Kisiel, 2006).

Learning communities are similar to learning collaboratives in that they extend over time, but they may not have all of the features described above. For example, individuals rather than teams may come for training, or metrics may not be an intrinsic part of the training process.

The Social Work Field Placement Model

This training model, developed by the National Center for Social Work Education and Workforce Development of the National Child Traumatic Stress Network (NCTSN), has been used to train graduate students in social work in several evidence-based trauma treatments, including CPP. It proceeds in stages. First, experienced licensed clinicians who serve as field placement instructors are trained in the practice, typically in a 2–3-day seminar. These clinicians then carry cases and receive on-going consultation on their clinical work using the model. Groups of graduate students are given basic trauma training and some training on the evidence-based model that they will be implementing as part of their graduate school course work. They are assigned to field placements with one of the trained instructors and, after their assignments, they receive supplemental training in CPP or another evidence-based practice. They are assigned CPP cases in their field placements and receive supervision from their field placement instructors, as well as periodic consultation from the CPP trainer. The CPP trainer also provides continuing consultation to the field placement instructors. This consultation covers material that is relevant to their cases as well as to issues of supervision.

Replication Practices at Work

Below are examples of the training models used in three different efforts: (a) building regional capacity in high–quality early childhood mental health services, (b) creating learning communities to enhance collaboration with juvenile courts, and (c) building capacity in evidenced-based trauma treatment through a social work field placement model.

The Illinois Child-parent Psychotherapy Learning Collaborative

The Illinois Child-parent Psychotherapy Learning Collaborative (ILCPPLC) is an early childhood mental health training and capacity building initiative that brings CPP to Illinois clinicians and families. The ILCPPLC is modeled after the NCTSN's Learning Collaborative, but is unique in that it involved a private foundation. The Irving Harris Foundation (the Foundation), a longtime strategic grant-maker in the area of early childhood mental health, funded the ILCPPLC in the hope of meeting three aims: (a) increasing local clinical capacity to serve young children who experienced trauma; (b) developing a cohort of trainers that could sustain CPP in the region; and (c) developing a critcal mass of trained early childhood mental health professionals who could use their knowledge and expertise to advocate for the mental health needs of very young children.

The Foundation has a long history of partnering with Chicago-area early childhood, family support, and domestic violence programs to provide quality prevention and intervention services to families. Although this effort prevented many young children from experiencing some of the long-term effects of violence and other forms of trauma, including long-term mental health issues and low-education attainment, many clinicians, policymakers, and private stakeholders continued to identify a critical need along the prevention-intervention-treatment continuum for high-quality clinical services for young children exposed to trauma. Mental health services were the missing link for some of Illinois' most vulnerable young children. In spite of this perceived need, Illinois, much like the rest of the country, was reeling from the effects of the national recession, making it increasingly challenging for agencies to provide services to existing client populations and even more challenging for them to fund professional development and training to meet new or increased service demands.

To help fill this gap, the Foundation partnered with the Child Trauma Research Program and Erikson Institute to take the next step along the prevention-intervention-treatment continuum for children exposed to violence and trauma and established the ILCPPLC. The ILCPPLC was developed at a time when Illinois was ripe for a regional learning collaborative. There existed a state-wide effort to build trauma awareness in systems serving children, and there were few well-established collaborative partners in early childhood mental health who had trauma expertise. In addition, Illinois had a history of using CPP to serve traumatized young children: in 2008, CPP had been successfully piloted in the state's child welfare system and well-received by families and by clinicians. The Foundation also believed that Illinois could capitalize on the early successes of CPP in the state by using a relatively modest grant to duplicate the learning collaborative model developed by NCTSN and use it to training Illinois clinicians in CPP.

In funding the ILCPPLC, the Foundation sought to enhance services to young children and their families. The Foundation also recognized that using this training model to bring CPP to a defined region, first in the Chicago area and later across the state of Illinois, held the real possibility to facilitate a deeper collaboration among participants in the training that would not only improve practice but also affect policy. Working together, the teams trained in CPP within Illinois would be able to move beyond

clinical service delivery in an evidence-based practice to affect a broader systems change. The learning collaborative model facilitates interaction and peer learning among the participating teams. By training teams located within a geographically defined region, the Illinois initiative would capitalize on shared learning and naturally occurring collaboration to:

- Minimize the need for participants to incur the burden of travel expense in a time when agencies that serve poor and otherwise marginalized families are already stretched to the breaking point because of diminished public funding;
- Create a network of programs using a single treatment model to serve traumatized young children that share resources and referrals;
- Create an opportunity for agencies to join together to advocate for increased attention to the mental health needs of young children who experience trauma; and
- Use a train-the-trainer model to build a training cadre to ensure continued capacity building and ongoing training to clinicians as they work to provide quality services to children and their families.

The ILCPPLC has trained two cohorts, each cohort including seven programs, with approximately 35 licensed or license-eligible clinicians and supervisors. A deliberate mix of larger and smaller programs was sought for each cohort, with an emphasis on the cultural and ethnic diversity of both clinical staff and the families they serve. As in all learning collaboratives, program teams were required to include clinicians, supervisors, and directors and policy makers, to obtain maximum impact by ensuring that CPP was understood and endorsed at all levels of each program. The ILCPPLC also worked to ensure that both mental health centers and domestic violence programs were represented in both cohorts. The first cohort was focused on the Chicago metro area, while the second cohort expanded to include two programs outside of this area, one in southern Illinois, and one in the northwest portion of the state.

As part of the strategy to expand the capacity of a regional CPP training effort, Patricia Van Horn, one of the developers of CPP, trained the first cohort working with two Illinois trainers. The Illinois trainers became the faculty of the second cohort, with some continued mentorship and support from Dr. Van Horn, who remains as a consultant to Illinois as CPP is being imbedded into local programs. In this way, the Child Trauma Research Program, where CPP was developed, continues to support CPP training in Illinois while simultaneously ensuring that trainers within Illinois are able to offer continued training that will sustain the practice in the region.

> Children's real protective relationships with their attachment figures interact with their internal worries about emotional and physical safety.

One of the lessons emerging from the ILCPPLC's two cohorts is the challenges of embedding CPP practice in a time of fiscal uncertainty. Some clinicians left their agencies in the middle of training, with financial pressures often noted as the reason for leaving. At the same time, it was clear that the participants felt great value in the ongoing aspect of the training and the ability to connect with other providers who struggled with similar issues with their clients. In an effort to continue to support the cohorts, the ILCPPLC included an additional 1-day training and case consultation session. The high attendance from both cohorts suggests the need to develop ongoing support for programs even after the learning collaborative's scheduled trainings end.

The ZERO TO THREE Safe Babies Court Teams

Abuse and neglect is frequently related to serious developmental and social–emotional consequences for infants and toddlers. Further, the early traumas experienced by these vulnerable young children can be further perpetuated by the institutions designed to protect them such as the foster care system where they may experience multiple placements, infrequent visitation, further abuse or neglect, and delays in achieving permanency. In collaboration with ZERO TO THREE Safe Babies Court Teams and two centers in the NCTSN (Louisiana Rural Trauma Services Center and Early Trauma Treatment Network), a CPP learning community training was organized for providers and supervisors whose primary work is with abused and neglected young children in juvenile court. The training itself was similar in format to the learning collaborative model described above, and it shared much of the basic content found in the Illinois and NCTSN learning collaboratives to allow agencies to implement CPP. What set this training apart was specialized additional content to support clinicians working in court settings where unique issues related to how to best serve the infants, toddlers, and families frequently emerge. These issues are sufficiently similar across sites, and sufficiently vexing to clinicians who are involved in the cases, that a training focusing on issues particular to juvenile court-involved children and families seemed justified. Clinicians from 10 different jurisdictions and nine states participated in the CPP training with the goal of building a network of clinicians that shared similar concerns to support their becoming more skilled in working in juvenile courts to help the youngest, most vulnerable children in the child welfare system.

Some of the issues addressed during the training included: the complexities of whom to work with during concurrent planning; ways to build trust with parents when all of the information gathered and therapeutic work will be reported to the court; how to prepare court reports to reflect the relationship-based evaluation and CPP in ways that are most helpful to judges to have more information to guide their decision making; and how to communicate with court personnel, child welfare, and others about the importance of CPP to help strengthen the parent, foster parent, or caregiver's relationship with the child with the goal of achieving permanency as expeditiously as possible.

Like the ILCPPLC, the Safe Babies Court Teams learning collaborative had systems change as one of its goals. Specific content helped clinicians working in juvenile court learn how to work with a multidisciplinary court team to develop a more trauma-informed court and influence the other systems working with juvenile court to also be more trauma-informed. The Safe Babies Court Team learning collaborative saw training around collaboration with a multidisciplinary group of service providers as of equal importance with specialized CPP training. The two kinds of knowledge were strategically linked in a single training to help clinicians become more effective partners with other systems serving children in care.

The National Center for Social Work Trauma Education and Workforce Development

The National Center for Social Work Trauma Education and Workforce Development ("the National Center"), which is funded by the Substance Abuse and Mental Health Services Administration, is a uniquely designed program whose mission is to build the capacity of social work professionals to provided trauma-informed assessment and treatment to children and adolescents primarily in communities of color living under adverse circumstances. Trauma-focused, evidence-based practice is greatly

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The roles of parents and children in the family, as well as the relationship between the nuclear family and the extended family, are culturally determined.

needed in communities where young children are exposed to chronic, toxic stress from witnessing family and community violence, experiencing child abuse and neglect compounded by the additional stress of poverty and racism.

The National Center addresses this issue by first preparing licensed social work field instructors so they, in collaboration with social work schools, can prepare the next generation of trauma-informed social work practitioners. Social work field instructors receive didactic course work from trainers in one of several evidence-based interventions, including CPP; Attachment, Self-Regulation, and Competency; Trauma-Focused Cognitive Behavioral Therapy; and Trauma-Systems Therapy (www.ncswtraumaed.org). They then begin using the model by taking on their own treatment cases and receive case consultation twice a month for a period of time determined by the intervention developer, 18 months in the case of CPP. The following year, field instructors are assigned second year social work students who chose to take a clinical elective course which is adapted from the NCTSN Core Curriculum on Childhood Trauma which is currently under development by a network task force Layne et al., 2011; Strand, Abramovitz, Layne, Robinson, & Way, in press). Once the students complete this course, they too receive the 2–3-day training in one of the models mentioned above. The student is then assigned treatment cases in the agencies where they are doing their field work and are supervised by their field instructors. The field instructors continue twice-monthly case consultations with the CPP trainer, discussing their own ongoing cases as well as the supervision of their students.

The collaboration for the National Center is between the Fordham University School of Social Service and Silberman School of Social Work at Hunter College and partners with an additional seven university schools of social work around the country, including schools in Massachusetts and Louisiana. One of the authors (Henderson) provides the CPP training and case consultation for the Fordham and Hunter Schools of Social Work field instructors and students and has trained three cohorts of field supervisors and students over the past 3 years. Another author (Osofsky), with her team, supervises the CPP trainer working in Louisiana.

One of the advantages of this model for the dissemination of CPP is that capacity building begins immediately. Once the field supervisors complete the didactic training, they begin to work with families within their agencies using CPP. The enthusiasm of the program developers is contagious and transfers directly to the field instructors. Their eagerness to learn and practice CPP propels them to take on at least two treatment cases. Their attendance on the case consultation calls is excellent and within a short period of time they begin to feel safe enough to move from discussions of case management to more in-depth discussions of moment-to-moment interventions in the treatment. These discussions then move to countertransference issues as they continue to gain support from their group.

Among the limitations, similar to the Illinois model, most field instructors continue for as long as 18 months in the case consultation calls but not all complete this part of the training. Several supervisors have left agencies when clinics and hospitals were forced to close down programs because of economic challenges. A few shifted to different, more administrative, positions. Therefore, as in all trainings to perform trauma interventions, the CPP consultant needs to listen carefully for signs of burnout and secondary trauma and continuously remind supervisors and student about methods of self-care when working with such challenging cases.

This past academic year, an additional bi-weekly case consultation call was added for the student group in order to augment the supervision they receive in their agencies. Because the students are all working in different agencies, this addition provides them with group support and an additional learning experience as they move into their CPP cases. This has been a positive experience for the students as they struggle together on very difficult cases. It is a learning experience for the trainer or consultant as well. Many of the students (and field instructors or supervisors) are naturally gifted and on board with the basic concepts from the start. Others need ongoing support in developing their case formulation and clinical reasoning skills. By working directly with the students, the consultant determines which areas of learning need to be emphasized in future training. For instance, there have been entire case consultation sessions used to discuss cases that actually do not belong in the CPP model. The discussion turns to why not and what other methods of intervention are available, including variations of CPP. It is possible that in the pressure to provide CPP cases, supervisors assign cases for assessment with the hope that they are ready for CPP. Helping students and supervisors know when CPP is not the treatment of choice becomes part of moving them to greater understanding of the case formulation process.

As in Illinois, New York City and state are embracing the need to bring high-quality mental health services to very young children as a result of a major advocacy effort by groups such as the New York City Early Childhood Mental Health Workgroup and the New York Zero to Three Network. Through recommendations in two white papers written over several years, the city and state adopted the position that mental health challenges (and therefore mental health

services) begin at birth, rather than clinging to the old view that children less than 6 years old do not have legitimate mental health service needs. This major shift resulted in a greater understanding of the gaps in services for young children birth to 5 years old in the state. As school readiness and social–emotional development become part of the regular dialogue on the city and state levels, and as our child welfare agencies begin to recognize trauma as a major factor in the lives of young children and their overall development, evidence-based treatments are now in high demand. The National Center for Social Work Trauma Education and Workforce Development has addressed the urgent need for capacity building in the metropolitan area and is a model for continued capacity building across the country.

Limitations

The major limitation of the replication work discussed in this article is that neither training and dissemination model has been empirically tested or validated. There is one study that showed that foster children treated with CPP by clinicians trained using a learning community-style training had better outcomes than did a matched sample of foster children who received intervention as usual (Habib et al., 2008), and a second study that was based on the same population demonstrated that clinicians trained in a learning community could deliver CPP in a way that resulted in good outcomes for minority foster children (Weiner, Schneider, & Lyons, 2009). These small sample studies that provide some evidence for the efficacy of learning community training models are, however, the only ones with a comparison group that examined the clinical and functional outcomes for children treated with CPP by community clinicians. There are no randomized trials examining the efficacy of the field placement capacity building model for dissemination.

A second limitation is the fact that there are currently no well-developed instruments that examine clinician fidelity to the CPP model. Indeed, the fidelity measures were noted as a weakness in the study cited above (Habib et al., 2008). The development of fidelity measures is a challenge in CPP because the CPP manual does not prescribe particular content that should be delivered during a given session, leaving checklist fidelity measures less relevant for CPP. Fidelity measures are currently in development, but research will be needed to determine whether those measures (a) improve the quality of training efforts or (b) are able to show that interventions with demonstrable fidelity to the model result in significant improvement in child and family level outcomes.

CPP is one of very few evidence-based interventions designed for traumatized infants, toddlers, and preschoolers.

Third, CPP may not be equally effective for all ethnic and cultural groups. The studies that form its evidence base oversampled African American and Latino families as well as families with low socioeconomic status, and it was found effective for a sample of foster children of whom more than 70% were African-American, Latino, or mixed race (Weiner et al. , 2009). Thus, CPP can be said to be effective for those groups. CPP has not, however, been evaluated with families from other cultures, including Asian and Middle Eastern cultures.

Finally, CPP training is long-term and expensive. Some clinicians may drop out before training is completed, and in this era of economic hardship where the funds that support training and intervention are at a premium, not every agency or clinician who wants CPP training may have access to it. In fact most replication training conducted to date, including the training described in this article, has been supported by either public (NCTSN) or private (Irving Harris Foundation) grant funding.

Future Directions

Future directions for CPP replication are determined by its limitations. Well-developed fidelity measures are an essential first step to carrying out the research necessary to evaluate these training models, both from the point of view of clinician uptake of the model and from the point of view of child outcomes. Larger-scale studies, perhaps randomly assigning agencies to treatment models, will help determine the most effective means of community replication.

CPP is one of very few evidence-based interventions designed for traumatized infants, toddlers, and preschoolers. Because it has been demonstrated efficacious with a variety of populations across this age-group, there has been a great deal of demand for training to support CPP replication. There is anecdotal, and some preliminary empirical, evidence that the training models described in this article will support community clinicians in learning the model and delivering it with sufficient fidelity to help parents restore their children to positive developmental trajectories.

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Integrating Infant Mental Health Into Primary Health Care and Early Childhood Education Settings in Israel

The "Mediational Intervention for Sensitizing Caregivers" Approach

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Helping primary caregivers identify and understand the delicate interplay between cultural, emotional, and cognitive aspects of infants and toddlers' individual and environmental characteristics is challenging. To help alleviate this challenge, the Irving B. Harris Program for Infants, Toddlers, and Their Families at Bar-Ilan University (hereafter, "the Harris Program") applies the Mediational Intervention for Sensitizing Caregivers (MISC) comprehensive developmental approach to help adults understand their role in child development. The Harris Program uses this model to integrate infant mental health best practices into systems (i.e., primary care and early childhood education settings) in Israel.

The MISC approach, developed by Pnina S. Klein, focuses on enhancing the quality of adult–child interactions. The efficacy and predictability of this approach has been demonstrated in a series of studies with different populations in Israel and around the world (Jaegermann & Klein, 2010; Klein, 1996, 2003; Klein, Laish-Mishali, & Jaegermann, 2008). MISC is anchored in a comprehensive theoretical framework that combines developmental psychology, education, and neurocognitive sciences.

The quality of an adult–child interaction is strongly affected by the adult's behaviors that represent sensitivity and synchronized responsiveness, matched to individual child characteristics. These behaviors include the basic emotional messages transmitted to the child—namely, that she is loved and safe and that it is worthwhile for her to act and react. Synchronized responsiveness establishes the possibility for longer chains of communication (a ping-pong–like game between the adult and the child), which represent higher quality interactions. Emotion and communication variables and exchanges are essential for the occurrence of optimal learning experiences.

Abstract

The Mediational Intervention for Sensitizing Caregivers (MISC) model is a comprehensive developmental approach to help adults understand their role in child development by enhancing the quality of adult–child interactions. This article describes how the Irving B. Harris Program for Infants, Toddlers and Their Families at Bar-Ilan University integrates infant mental health into two different public systems serving infants, toddlers, and their families in Israel. The authors also describe an educational training program for child care workers based on the MISC approach.

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The quality of an adult–child interaction is strongly affected by the adult's sensitivity and responsiveness.

MISC is based on the videotaping of adult–child interactions and the subsequent analysis of these interactions together with the caregiver. This type of analysis permits the quality of the interaction to be quantified and encourages the adult to use developmentally appropriate behaviors in interactions with the child. The MISC approach includes the following three components:

1. Comprehensive, theoretical rationale that conceptualizes the main components of quality adult–child interaction.
2. Awareness of children's "mental diet"—namely, the frequency of various types of specified experiences in children's daily life. Similar to a nutritional diet, an optimal mental diet with emotional and cognitive (mediational) ingredients should be varied and balanced. A quality mental diet is crucial for children's optimal development.
3. Use of "literacy of interaction"—namely, identifying (or "reading") behaviors that build quality adult–child interactions and enhance infant mental health and future development.

The following examples reflect the Harris Program's efforts to integrate infant mental health into two different public systems serving the majority of infants and toddlers and their families in Israel.

Training Caregivers in Public and Private Day Care Systems

A growing number of infants and toddlers in Israel spend most of their waking hours in public and private day care settings. Thus, it is especially important to focus on the quality of their interactions with the caregivers, as the latter become a major component of the children's mental diet in the day care context. Improving the quality of caregiver–child interactions is one of the main objectives of the training program. A major challenge found when working to improve quality of caregiver–child interaction in the field of education is the lack of correlation between theoretical knowledge and its application in everyday work with young children. To bridge this gap and to maintain the relevance of theory and research in practice, Klein and colleagues (Klein, Kraft, & Shohet, 2010; Shohet & Klein, 2010) developed an educational training program based on the MISC approach that combines infant mental health with pedagogical principles.

The Training Process

The training program is based on regular bi-weekly visits of a MISC expert trainer in the educational setting and consists of individual, as well as group, caregiver mentoring. The process is described hereinafter.

1. **IDENTIFY THE CAREGIVER'S PERSONAL AND CULTURAL CHARACTERISTICS.** The trainer makes both structured and unstructured attempts to understand each caregiver's child-rearing views, objectives, needs, and expectations. The trainer communicates respect for the caregivers' opinions and beliefs, thereby affording an opportunity for sensitizing the caregiver to ecocultural considerations in their work with children and families.
2. **CREATE A "BASELINE" OF ANALYSIS IN THE DAY CARE THROUGH VIDEOTAPE AND INTERVIEWS.** The trainer videotapes each group of day care children interacting with their caregiver. This video represents the caregiver's initial caregiving competencies. In addition, the trainer evaluates the quality of classroom environments on the basis of observations and interviews with the day care staff according to scales designed to assess the global quality of educational programs (Harms, Clifford, & Cryer, 1998; Harms, Cryer, & Clifford, 2003).
3. **CREATE CAREGIVERS' PERSONAL INTERACTION PROFILE ON THE BASIS OF VIDEOTAPED INTERACTION.** The trainer builds a personal profile of interaction that is based on the analysis of each caregiver's videotaped interaction. The profile reflects the frequency of the caregiver's mediational behaviors during her interactions with children. This process allows the trainer to quantify the quality of caregiver–child interactions. The trainer and the caregiver jointly identify and conceptualize the interactional characteristics according to MISC concepts. The caregiver learns to understand both the child's and her own behavior within a meaningful framework, thereby imbuing her actions with meaning. This process of "reading" her behavior (also known as "literacy of interaction") enhances the caregiver's awareness of and sensitivity to her own interactions with young children.
4. **DESIGN A TRAINING PROGRAM BASED ON IN-SERVICE AND VIDEO-TRAINING MODULES.** Using the personal profile of interaction as a frame of reference, the trainer and the caregiver clarify training objectives, which become the basis for a long-term, dynamic training process.

   In-service training. In-service training takes place in the classroom or on the playground. The trainer accompanies an individual caregiver in his day-to-day educational work. In doing so, the trainer helps him learn how to scaffold his behaviors and emotions to improve the quality of his interaction with the children in various modalities, such as asking questions, providing meaning to behaviors, and helping the children in problem solving. Specific caregivers' interaction characteristics, which were identified previously in the training process, are addressed in the current context. This is a powerful learning experience for the trainee because it occurs in real-life situations that provide significant support and immediate feedback.

In Israel, more than 90% of infants and toddlers and their parents regularly visit public family health centers for well-baby visits.

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A major challenge when working to improve the quality of caregiver–child interaction is the lack of correlation between theoretical knowledge and its application.

Video training. Video training takes place outside of the classroom environment and can take the form of group or individual sessions. The trainer and trainees observe, analyze, and discuss videotaped interactions in diverse situations throughout the day. During the discussion, the trainer focuses on positive aspects of the interaction, encouraging the trainees to increase the frequency of such behaviors and to think of ways of applying them to other situations.

5. **EVALUATE TRAINING EFFICACY.** Re-evaluations of the baseline measures at the end of the training process indicate an improvement of caregivers' quality of interaction with the children and in classroom quality measures. Changes in personal interaction profiles are expressed in an increase in the appearance of most criteria mentioned earlier as well as in caregivers' ability to verbalize the change in their behavior and in the environment. We implement this program in caregiving and educational settings that serve diverse populations, including those settings that serve children from multicultural backgrounds and children at risk (i.e., children who experience ongoing war trauma).

Training Public Health Nurses

In Israel, more than 90% of infants and toddlers and their parents regularly visit public family health centers for well-baby visits. Natural parent–child interactions occur during these visits. The MISC training for public health nurses enhances the ability of nurses to observe and analyze parents' behavior and to encourage them to use various criteria of quality developmental interaction with the child (adult behaviors that were found to have a positive influence on child development). The approach is a systematic mediational process that targets, in this case, the enhancement of both nurse–parent and parent–child interactions. The training program was administered in collaboration with Israel's Ministry of Health—Mother, Child and Adolescent Department, Central District Office.

Prior to training, program administrators visited centers that serve different populations of parents and children (including minority groups—namely, Ethiopian Jews, Orthodox Jews, and Israeli Arabs) to ensure that the training program was culturally sensitive to minority groups in Israel. Administrators videotaped parent–child interactions at each of the centers, and these videotapes served as a basis for the training program. A written consent from parents was received prior to the intervention in the centers. Because of the nurses' heavy workload, the original training program was modified and shortened to fit the nurses' needs. However, a training process similar to the one described above was implemented for the public health nurses. In an effort to formulate the training for the nurses' specific needs, the Harris Program administrators intentionally worked to raise the nurses' awareness to (a) the particular ethnocultural characteristics of the families, (b) the major risk factors, and (c) the children's sensory processing and self-regulation. Overall, the primary focus of the training was on the adult–child interactions videotaped at the family centers prior to the training. The analysis of the videotapes focused on the following elements:

1. Developmentally appropriate adult behaviors to enable quality adult–child interactions.
2. Conceptualization of the behaviors according to the MISC approach, including the creation of the adult's typical mediational profile related to the child's needs and to the "mental diet" provided.
3. Identification of adult behaviors and the child's developmental outcomes.

Nurses learned to use basic concepts relating to quality interactions and became acquainted with their meaning and with their positive impact on child development. A post-training evaluation consisted of semistructured interviews with participating nurses focusing on their ability to identify and support mothers' quality interaction. One of the major outcomes noted was the change in the nurses' attitude toward the parents from didactic "do and don't do" remarks to positive and rewarding comments regarding appearance of behaviors representing criteria of quality parent–child interaction.

Conclusion

In conclusion, infusing infant mental health into systems in Israel has been successful because of the basic MISC components of systematic simplicity in a diverse ecocultural fabric. Although infusing MISC has been successful, it has been noted that trainees need further support, scaffolding, and supervision that cannot be provided easily because of financial and time constraints. We recommend offering periodic follow-ups and support as needed.

With efforts to further integrate infant mental health into other public systems in Israel as encouraged by the Irving Harris Foundation Professional Development Network, MISC has been included in a new academic certification program for trainers in early care and education settings. The program is administered in collaboration

with the multidisciplinary Harris team at the Baker Center, Bar-Ilan University, and with the Ministry of Labor, Commerce and Employment, the governmental body that is in charge of day care programs in Israel.

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Implementing the Fussy Baby Network® Approach

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Abstract

Erikson Institute Fussy Baby Network® (FBN) developed an approach to engaging parents around their urgent concerns about their baby's crying, sleeping, or feeding in a way which builds their longer-term capacities as parents. This approach, called the FAN, is now in place in new Fussy Baby Network programs around the country and is being infused into existing home visiting programs as well. This article describes the core processes of the FAN, how to match these processes with what the parent needs in the moment, and illustrates the approach in three exemplary FBN national program sites in Arizona, California, and Colorado.

Although crying is an expected part of normal development, it can place babies and families at risk, including risk for child abuse, family stress, maternal and paternal depression, parent–infant relationship distress, and developmental and behavioral problems (Barr, Trent, & Cross, 2006; Gilkerson & Gray, in press; Maxted et al., 2005; Papoušek & von Hofacker, 1998). For the past 9 years, Erikson Institute Fussy Baby Network® (FBN) has been funded to develop, implement in Chicago, and disseminate nationally an infant mental health based, prevention home visiting program for families who struggle with their infant's crying, sleeping, or feeding during the baby's first year of life (Gilkerson & Gray; Gilkerson, Gray, & Mork, 2005). FBN holds a dual focus on helping parents with their urgent concerns about their baby in a way which builds their longer-term parenting capacities of confidence and competence in meeting their infant's needs. The hallmark of FBN is its approach to family engagement called the FAN (see Figure 1; Gilkerson, 2009) because of its visual similarity to a fan. The FAN approach helps to address the parents' urgent concerns by matching core intervention processes to what the parents are showing they can most use in the moment. Careful attunement and matching to the parents' experience helps stressed parents feel understood and not alone and fosters a sense of coherence during a difficult time.

The purpose of this article is to describe the FBN and the use of the FAN approach in the first three national sites: Fussy Baby Network® Phoenix at Southwest Human Development (SWHD), Fussy Baby Network® Oakland at Children's Hospital & Research Center Oakland, and Fussy Baby Network® Colorado at the University of Colorado School of Medicine. Each of these sites is a recognized center of excellence in infant–family services and is funded as part of the Irving Harris Foundation Professional Development Network to provide training in infant mental health.

Erikson Institute FBN provides ongoing training and consultation to FBN national sites through a structured dissemination process which supports sites as they move from exploration through implementation to sustainability of the model.

FBN Program Structure

Because parents are in crisis when they contact the FBN program, sites must be able to respond immediately to families with Warmline telephone support and have the capacity to offer a home visit within 24–48 hours of the first call. To reduce the stigma around reaching out for help, FBN programs strive to be universally available to any family with a baby less than 12 months old who struggles with their infant's crying, sleeping, or feeding. Thus, eligibility is parent-determined and is based on the parent's perception of the baby as challenging. Services are provided for free or on a fee-for-service basis, so no family is denied support for financial reasons. Enough time is allotted for an unhurried contact, whether on the Warmline or a home visit. Because of the complexity of needs, FBN specialists are experienced infant–family professionals, with backgrounds in fields such as mental health or child development. Each team must be interdisciplinary, including at least one professional with a health or allied health background. Reflective supervision and collaborative team process are essential to the model.

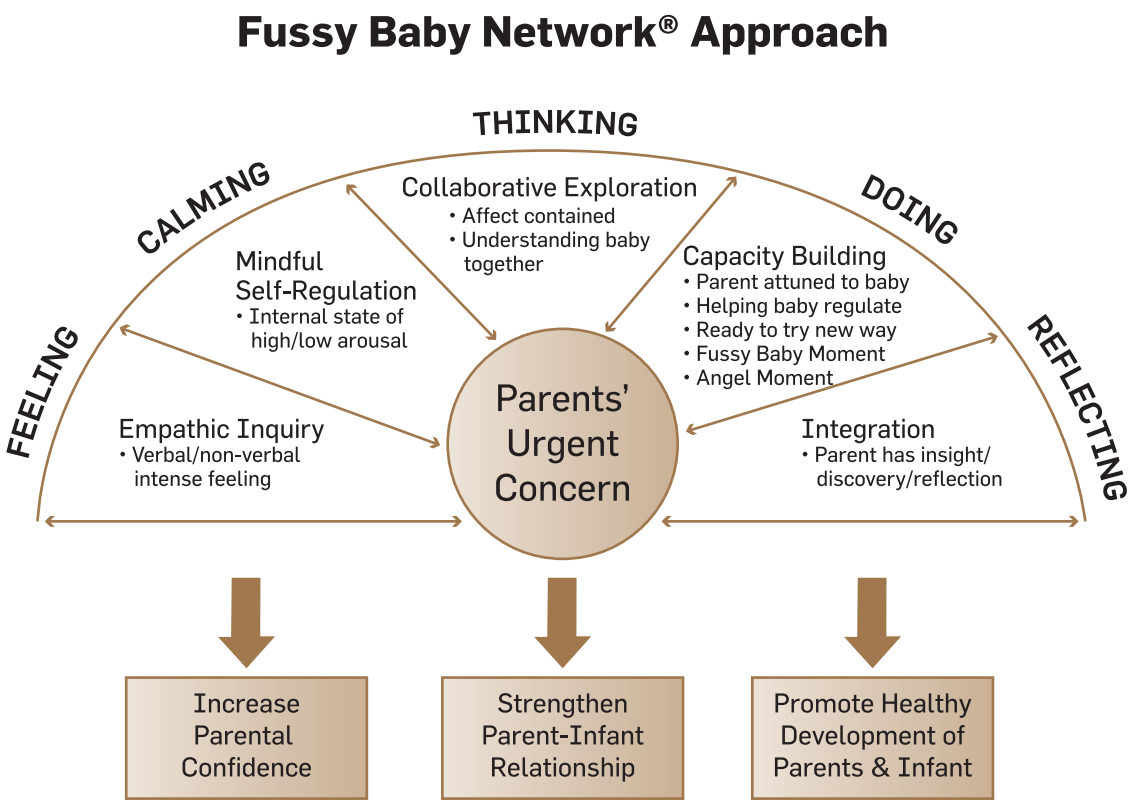
The FAN Approach to Family Engagement

The FAN is a conceptual model and practical tool for family engagement. At the center of the FAN (see Figure 1) is the parents' urgent concern which is dynamic and often changes throughout a visit or call. Around the urgent concern are the five core processes that the specialist has available to use to address the parents' urgent concern in a way that builds longer-term parenting capacities. As illustrated, the five core processes include Empathic Inquiry, Mindful Self-Regulation, Collaborative Exploration, Capacity Building, and Integration. The outer rim of the FAN presents the essence of each core process in one word: Feeling, Calming, Thinking, Doing, and Reflecting.

Matching Core Processes to Needs in the Moment

The core processes have been defined with guidelines around how to match the processes to what the parents are showing they can most use in the moment (e.g., when affect is present, Empathic Inquiry is most helpful; when affect is contained and parents want to understand the baby, Collaborative Exploration is appropriate). In addition, intervention strategies for each core process have been developed (Gilkerson, 2009). If the specialist has matched the core process to what the parent is showing, then the interaction typically flows. Specialists are trained to track the engagement in the moment, ask themselves: "Is this working?", and shift on the FAN as needed. The matching process is important as it is the experience of attunement that increases the likelihood that the parents will feel understood and not alone. When parents feel understood, there is more internal cohesiveness, and safety replaces anxiety. Parents feel calmer, at least in the moment and, with support, more able to access their internal resources.

Figure 1. Fussy Baby Network® FAN Approach



Source: © Gilkerson 2011 Erikson Institute Fussy Baby Network

Arc of the Visit

To provide a containing function, the core processes are also used to structure a visit. The visits typically follow an arc, beginning with Empathic Inquiry, where the Specialist invites parents to share their experience by asking, "What has it been like for you to take care of your baby?" In the middle, Collaborative Exploration is used to check in with the parents by asking, "I'm wondering if we are getting to what you most hoped we would talk about?" At the end, Integration is used to build coherence by offering parents time to reflect about their baby ("If you could describe your baby today in three words, what would they be?") and about what has been most meaningful to them ("We have talked about so many important things. I'm wondering if there is something you would like to remember or hold on to that would be helpful to you in the next week?").

Beyond the Arc of the Visit, there is no requirement that all the core processes have to be present in a visit or Warmline call. The use of the core processes is fluid and shaped entirely by what is happening in the moment. In the following sections, we provide a brief description of the three national sites and share a vignette which illustrates the FAN approach.

FBN Phoenix

FBN Phoenix is a program of SWHD, a nonprofit educational and human services organization that provides comprehensive early childhood services. In July of 2007, FBN services were integrated into SWHD's already successful Birth-to-Five Helpline, a toll-free number for Arizona families to access consultation on child development. Leaders at SWHD recognized immediately that the model was consistent with the agency's overall approach because of FBN's unhurried pace, nondirective and individualized focus on infant–parent relationships, rather than on generic parenting "tips and tricks" and advice-giving. FBN Phoenix, FBN's first national site, is firmly established at SWHD. The FAN framework has proved to be of such value that it is being infused into other programs in the agency, including its statewide early childhood mental health consultation program.

FAN Approach in Action

Angelica, the young mother of a 7-week-old boy, phoned the Helpline the day after what she called, "the worst day ever." Her infant, she said, "just won't sleep." She described him as "very fussy" and thought that perhaps his fussiness was the result of his not getting sufficient sleep. She worried though that the baby could be in pain or have some constitutional problem underlying his fussiness and poor sleep. It did not help, she noted, that his 4-year-old brother would inadvertently or at times deliberately awaken him. She felt guilty that "there was not enough of me to go around." After a 40-minute phone conversation, a home visit was scheduled.

Early in the home visit, Angelica revealed somewhat reluctantly that she often placed the baby in her bed to get him to sleep. The specialist quickly became aware of her own concern for the baby's safety. To balance her anxiety over the baby's safety with understanding the mother's perspective, she moved to Mindful Self-Regulation, slowing her breathing in an effort to steer clear of an impulsive display of disapproval that would surely work against her alliance with the mother. She knew that sleeping arrangements are very personal to families and carry great cultural meanings. Although this could have been a moment to educate the mother about infant sleep guidelines, the specialist chose to continue to explore with the mother and asked what she meant when she said, "I know I shouldn't have him in bed with me." Angelica talked at length about her ambivalence about encouraging the baby's independent sleep. On the one hand, she wanted him to learn to fall asleep on his own in his crib for better sleep, and to allow the rest of the family to get more sleep. On the other hand, she knew this would be "my last baby," and she wanted to be close to him as much as possible. The specialist empathized with the mother's mixed feelings. When all was said and done though, the mother thought that developing some systematic way of helping the baby sleep in his crib would be best for him and the rest of the family.

Through Collaborative Exploration, Angelica and the specialist discovered that both mother and father agreed that the baby liked being swaddled. To access parents' intuitive competence, a strategy is to ask parents about their hunch about what might help their baby. The mother's own hunch was that it would be better to do something with the baby after he breastfed and before he was placed in his crib. Moving into Capacity Building, the specialist and mother co-created a routine that involved nursing the baby, then swaddling him and holding him for a bit in a particular position that the mother noticed he liked, then placing him in his crib to sleep. When offering ideas or information, the FAN approach is to "say it in one breath" and then explore the meaning with the parent. The specialist offered one idea which she felt might enhance the parent's plan: "Sometimes," the specialist noted briefly, "babies like a hand lightly on their head as they're settling into sleep. I wonder if that would be helpful for your baby?" The mother was eager to try this approach during the visit with the support of the specialist. The specialist stayed with the 4-year-old when Angelica took the baby to his crib, talking to him about how the two of them were helping his mom get the baby to sleep by playing quietly. After 15 minutes, the mother returned to the living room triumphantly. The baby was asleep in his crib. Ten minutes later, however, the baby made some noises and the 4-year-old took off for the baby's room shouting, "He's awake!" Angelica followed behind and retrieved the baby. Frustrated, she said to the specialist, "And this is what we do all day long." Here was the Fussy Baby Moment, an opportunity to see the very problem that distressed the mother so much about her baby. The specialist moved into Empathic Inquiry, acknowledging how disappointing it must be that the mother's new plan had seemed to work so well but lasted only briefly. Angelica agreed and added that it would have been better if her older son had not "finished the job" by running into the baby's room. "What do I do?" she asked the specialist. Moving into Capacity Building, the specialist said, "I think you're right that you have to find something to occupy your 4-year-old while you are putting the baby down and for a bit after he is asleep. After all, even though the baby stirs and makes noises it doesn't mean he's fully awake or that he won't go back to sleep." and asked: "Does that make sense to you?" Angelica spent the remainder of the home visit developing sleep routines for both of her sons, which she intended to share with her husband. She also planned to engage her 4-year-old in making crafts when she was putting the baby down for naps or bedtime. When asked for three words to describe the baby, Angelica said, "sweet, fussy, and trying to learn to sleep." When asked what she wanted to hold onto from the visit, Angelica said, "It's going to get better."

On a follow-up home visit a week later, things indeed were better. Angelica was happy to report that her baby was sleeping longer periods of time in his crib and her 4-year-old was quite happily enrolled in helping with the sleep plan, saying, "If I do this [crafts] while Mommy is putting the baby to sleep, then we can play."

FBN Oakland

Prior to the inception of FBN Oakland, Children's Hospital & Research Center Oakland had a variety of programs to provide early childhood mental health services for infants and young children from low-income, often high-risk families; however, the referrals often came in the second, third, or fourth year of life. Many of these children had early histories of crying, sleeping, and feeding difficulties. Depression

PHOTO: ©ISTOCKPHOTO.COM/OKANMETIN

Fussy Baby Network programs strive to be universally available to any family with a baby less than 12 months old who struggles with their infant's crying, sleeping, or feeding.

was common among the parents, and parent–child relationships had often gotten off to a rocky start. The FBN model showed promise to reach families much earlier and, as needed, to serve as a portal of entry to other treatment services. Fussy Baby Network® Oakland started with a small part-time staff and a strong commitment to make this new service work. By partnering with the hospital's clinics and community agencies, the agency has achieved its original goal of reaching families significantly earlier with 60% of the FBN referrals coming in the first 6 months and is starting to use the rapid response feature in other programs.

FAN Approach in Action

The emergency department referred baby Amir, who was almost 3 months old and had been brought to the emergency department many times by his frantic parents because of his inconsolable crying. Each time, the parents were sent home with a baby who was pronounced healthy, but fussy. Amir was the first child of a couple from Morocco. The father spoke English fluently; his wife was a recent immigrant and spoke only Arabic. Because of language needs, an Arabic-speaking clinician from the regular infant mental health team was paired with a FBN specialist. The team anticipated a short-term case and speculated that perhaps the mother was depressed because of her recent separation from her family of origin. However, the family and baby took the work in a very different direction, as Amir turned out to be one of the babies whose early crying was related to longer-term regulatory challenges.

On the first visit, both the mother and father were present. The visit began with Empathic Inquiry by asking the parents what it was like for them to be caring for little Amir. Both parents eagerly began to talk, "We had no idea that a baby could cry so much. Is something wrong with him?" The team knew that it was especially important for these worried parents that they take the time to "see the baby that the parents see" because physicians had repeatedly reassured them that their baby was fine. Using Collaborative Exploration, the team wondered with the parents what they thought might be the problem. The mother speculated, "I think he's mad he's not in Morocco. It's so different here—the climate, the food. Could that be what's wrong?" Then, both parents began to talk about how frightened they had been in the emergency room, "The doctor never came, my baby got more upset, and I was afraid he was going to die." The specialist used Empathic Inquiry to validate their feelings and say they could take all the time they needed to talk about what had happened. The team noted the parents' solid support of one another and their deep and persistent fear that something might be wrong with their baby. Staying in Empathic Inquiry, the specialist said, "It must be so frightening to feel that something is wrong with your baby and not know the answer." The team sensed that their careful listening led the parents to feel as if this was the first time someone could hear the depth of their concerns.

On the next visit, it became clear that Amir, while healthy, was indeed a fussy baby. After a time in Empathic Inquiry, the parent's initial distress seemed somewhat contained and they wanted help with his fussiness. Using Collaborative Exploration, they asked the parents what they had tried that helped Amir and what was most challenging for them. The mother shared at length all the things that she had tried, "I've tried everything and nothing worked." The hardest part for her was feeling criticized by everyone for his crying and very alone, missing her mother in Morocco. "My mother would know what to do" she said. Feelings now had taken precedence and the specialist shifted to Empathic Inquiry around the mother's longing for the comfort of her family. After a while, the mother began to talk about how hard these past days had been, with Amir crying for 2 and 3 hours at a time and looked directly at the specialist, saying, "I really don't know what to do." The mother was in a different place now, ready to focus on finding a way to help her baby. Returning to Collaborative Exploration to engage the mother in thinking about her baby, the specialist asked, "Would it be helpful if we looked together to think about what might help a little bit? Let's see if there is anything we can figure out." They watched Amir and discovered that one of the only things that helped him was a kind of upright posture, and being held and walked, particularly outside. The specialist asked the mother if she had tried a sling to help him be upright; she welcomed the suggestion which, over time, was very helpful. As they talked, it was clear that the mother was working very hard to understand Amir and that he was genuinely challenging. Capacity Building was used to validate her efforts even if he continued to be fussy, "Amir seems to need more help than most babies. You seem to know that about him."

On this visit, the team met Amir's 12-year-old cousin with severe autism who lived in the household. Mindful Self-Regulation helped both the clinician and specialist contain the momentary fear they each experienced, "Oh, no! Is this what Amir has?" Although the mother did not bring up the cousin's autism in relation to Amir, the team wondered if the parents' fears, like the fears that were just triggered in them, were about their baby having a severe disability like his cousin. Mindful Self-Regulation helped the team slow down, hold this question in mind, and not move too quickly to explore it, especially when their own emotions were stirred.

As the work moved into the third month, the team noted new regulatory challenges as well as a strong bond growing between Amir and his parents. Each session continued to start with Empathic Inquiry, offering parents the chance to share their worries and fears. The theme of something being wrong echoed frequently. On one visit where Amir's cousin

was very much a part of the experience, sitting close by and approaching the baby, the specialist thought that this might be the time to explore whether the mother thought Amir's challenges were like his cousin's. The specialist commented on how Amir's parents supported the cousin's gentle approach to the baby. The calm space opened up an opportunity for Collaborative Exploration about his disability and the parents' understanding of Amir's fussiness. The mother seemed relieved to talk about the worry this engendered for her. At several points during the visit, the team validated Capacity Building Angel Moments, defined in the FAN approach as moments when the parent and baby are fully engaged with each other and experiencing mutual pleasure. At the end of this visit, the mother described him as "handsome, sensitive, and smart."

At 15 months, Amir presented as a little boy with very pronounced sensory differences. His parents continued to cherish their son, but were often exhausted by his energy and persistence. At the end of a recent visit, his mother described Amir in this way, "Our baby is very demanding and can do many things. He is loving, very fussy, and finicky." Although his needs are challenging, Amir's developmental differences do not qualify him for Part C Early Intervention at this time. The FBN program continues to provide support as the family navigates their child's sensory challenges during each developmental transition.

FBN Colorado

With years of history working together through the Professional Development Network, leaders at Erikson and the Harris Program in Child Development and Infant Mental Health in Colorado began to explore the possibility of infusing the FBN approach into their existing infant mental health work in primary care and adding a FBN Warmline and home visiting component to provide prevention services. Through creative community collaborations, the program has served its 100th family and is now exploring how to adapt FBN services for military families. With a priority on prevention of Shaken Baby Syndrome/Abusive Head Trauma, the Harris Program will soon include in its statewide pilot to train and consult with early child care and education professionals, training based on the FBN Guide, titled *Partners in Care: Supporting Fussy Babies in Child Care* (Fussy Baby Network, 2008).

FAN Approach in Action

On the Warmline call 3 days prior to the home visit, Kelly, mother of 4-month-old Eli, called with urgent concerns around his feeding. Kelly lamented, "He feeds all the time, it feels like he is constantly breastfeeding and I never get a break." Sounding exhausted and desperate, she went on, "Eli needs to be attached to me in order to sleep at all." She stayed on the phone for only 10 minutes, stating that Eli has been much more challenging than her experience with her first child. Eli was born with a medical condition that did not allow him to have direct exposure to sunlight, "I feel trapped at home with these two kids and I just want a moment for myself to put Eli down so I can get something done around here." A home visit was scheduled.

> When parents feel understood, there is more internal cohesiveness, and safety replaces anxiety.

The FBN specialist rang the doorbell, and the door opened but it seemed like no one was there. The house was dark. "Hello?" whispered the specialist, using Mindful Self-Regulation as she tried to make sense of the situation. She heard a giggle and then she looked down. At the door, just below the doorknob, an adorable 20-month-old was looking up at her. A moment later, Kelly came into the room with baby Eli in her arms, emerging from what felt like darkness in the middle of a sunny Colorado morning. "Good morning," she said softly. "Good morning," whispered the specialist, matching the mother's tone and affect. As they moved to the living room couch, Kelly expressed her gratitude for the visit, gave big sister Lila a snack while turning on the TV, and asked, "Can you give me strategies to help Eli be less fitful and more independent?" Nodding that she had heard the mother's concern, the home visitor then asked, "Tell me what it has been like for you taking care of Eli these past few months?" Kelly burst into tears as she told her story.

The use of Empathic Inquiry provided the safety for Kelly to disclose difficult feelings of frustration, disappointment, and a sense of being completely overwhelmed: "Sometimes I think I made a mistake having another baby after such a good baby like Lila." The specialist listened empathically, allowing Kelly to express thoughts and feelings that are not easy for any parent to admit aloud. Baby Eli fussed as his mother cried and Lila, eating her snack while appearing to watch her show, listened and imitated her mother's sad expressions, seemingly without Kelly's awareness. The specialist moved back to Mindful Self-Regulation as she began to take in all that was happening in the room: the mother's sadness, the baby's fussing, the toddler's sadness, and the actual darkness with the blinds closed and the lights off. The house was so hot that beads of sweat had formed under her t-shirt. At that moment, the specialist felt overwhelmed herself and unsure where to take the visit. Mindful Self-Regulation helped the specialist use her own feelings of disorganization as a way to understand what the mother might be experiencing. She moved to Collaborative Exploration to see if finding a focus would help the mother and the visitor move forward. Collaborative Exploration provided just the right amount of structure to help organize the visit in the moment, resulting in a rich discussion of Eli's schedule and how his needs for care interfered with his sister's needs. This shared understanding led easily to Capacity Building as Kelly began to think aloud about a few small but meaningful ways to be with both children during the day, saying things such as, "Now that we're talking about it, I guess that he doesn't mind being in the sling listening to the dryer while Lila and I sort clothes together." She recognized the reality that this shared time would need to be in the early morning before the sun hit the laundry room in the back of the house.

Empathic Inquiry reemerged as Kelly began to pour out her fears for Eli, sharing "Sometimes it's overwhelming to think about all the little details of making his world safe for him. It takes so much of my time and mental energy I worry I have nothing left for Lila. I don't know what kind of life he will have; will it ever be normal?" She also talked about her loneliness as a member of a military family who recently relocated to Colorado, "I don't know anyone here yet to even help me. I'd like to try to go to some of the activities for moms on base, but it just feels impossible with Eli. It would be different if we were still at our last base where I had some friends but still—none of them has a baby like Eli." Mindful Self-Regulation was needed again as the specialist, a mother of a toddler, let herself feel what it would be like to stay inside all day with a toddler and baby and be so isolated in a new community.

Soon Eli began to fuss. Knowing this was a Fussy Baby Moment, the specialist said, "Do what it is you would normally do. I will be here. We have time." It was an hour into the visit, but the specialist knew the importance of letting the mother know she was in this with her.

Kelly moved to a big comfortable chair and began to feed and rock baby Eli, who was visibly drowsy. The specialist moved from the couch to the floor behind big sister Lila, who was peering around the closed blinds looking outside. They looked together at the world outside, sunny and bright. Mindful Self-Regulation reemerged for the visitor as she felt Lila's (and her own) sadness and longing to be outdoors.

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Sleeping arrangements are very personal to families and carry great cultural meanings.

Just moments later, baby Eli was asleep in Kelly's arms and she turned to the specialist and asked, "What now?" with a cautious smile. They talked together about what it might be like to put Eli down to sleep and Kelly, with great trepidation said, "If he sleeps in my arms, he will sleep longer." They thought together for a moment and the visitor, remembering that part of Kelly's urgent concern was to have time with Lila, wondered aloud, "I wonder what you might be able to do with Lila out here if you put Eli down in his room?" Capacity Building was underway as Kelly responded, "If Eli is in the back room, I could open the blinds for Lila?" Lila whipped her head around and gave her mother a big smile and began jumping. The specialist supported Kelly to try her new idea.

After putting Eli down, Kelly returned to the living room, knelt down beside her daughter, and opened the blinds. Kelly picked Lila up and they smiled as they walked the visitor out. There was much more work ahead. But for right then, even if only for a few moments, Eli was sleeping in his crib, Lila was in her mother's arms, and the two were smiling. The blinds were open. The front screen door let in a slight breeze to relieve the heat. And there was light.

Summary

The success of these sites is a tribute to their committed leadership and skilled FBN team and affirms the transferability of the FAN model. Through the process of implementation, it has become clear that the FBN orientation to the helping relationship and the specific FAN core processes are broadly applicable beyond the challenge of infant fussiness and provide practitioners and supervisors across settings with a practical tool for the "How" of working from a relationship-based perspective. FBN is currently working to infuse the approach into two national evidence-based models, Healthy Steps and Healthy Families America®, as well as expand the national network of FBN program sites.

FBN's vision for the future is that all parents who experience challenges with their new babies will receive early support to address their urgent concerns and that this support will be offered in a way that builds their longer-term capacities as parents. Expanding the FBN National Network through new FBN programs and through infusing the approach into existing systems of care is one step toward this vision. We invite you to join!

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Note

For more information about the Fussy Baby Network®, contact Linda Gilkerson at lgilkerson@erikson.edu.

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Altering the Developmental Trajectory of Public Policy

Three States' Success Stories in Infant Mental Health

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In developing policy, those closest to an issue—the advocates, researchers, program directors, and consumers—are best suited to give policymakers evidence of need and guide them toward solutions. Early child development professionals can influence early childhood policy by taking advantage of three key strengths: cultivating relationships, recognizing critical windows of opportunity, and articulating the robust science regarding the tremendous vulnerabilities and opportunities of early childhood. This article presents examples of policy initiatives successfully undertaken in Florida, Louisiana, and Minnesota that demonstrate the effectiveness of these strategies. Such strategies will comfortably and powerfully push infant mental health policies and practices away from "the biggest bang for the buck" to smarter investments that produce desired results.

"There can be no keener revelation of a society's soul than the way in which it treats its children."
—Nelson Mandela (1995)

Public policy is a reflection of society's values as reflected in funding priorities. Policy is driven by political, economic, and social forces that seem impenetrable for most early child development professionals, who may be more comfortable in playgrounds and classrooms than in legislative arenas. But early childhood professionals can influence early childhood policy, by taking advantage of three key strengths: cultivating relationships, recognizing critical windows of opportunity, and articulating the robust science regarding the tremendous vulnerabilities and opportunities of early childhood.

It is often said that babies develop in the context of relationships; in fact, Winnicott's (1960) classic quote boldly states, "There is no such thing as (just) a baby; there is a baby and someone." Similarly, for development of public policy, relationships provide essential scaffolding from which the blocks of public policy are built over time. Policy makers rely on those closest to an issue—advocates, scientists and researchers, program directors, and constituent consumers—to provide them with evidence of need and solutions. Those who are outside the policy environment must rely on policymakers, including legislators, state and federal government officials, and elected public officials, to create laws, rules, budgets, and other meaningful and responsive policy vehicles. Without relationships between those who make policy and those

Abstract

Early child development professionals naturally prefer playgrounds and classrooms to legislative arenas; however, their strengths, skills, knowledge, and data are sorely needed by policymakers who rely on those closest to an issue—the advocates, researchers, program directors, and consumers—to give them evidence of need and guidance toward solutions. Examples of policy initiatives successfully undertaken in Florida, Louisiana, and Minnesota demonstrate the effectiveness of cultivating relationships, recognizing critical windows of opportunity, and articulating the robust science of early childhood. These strategies will comfortably and powerfully push infant mental health policies and practices away from "the biggest bang for the buck" to smarter investments that produce desired results.

who are affected by it, even the wisest policies can be met with a "still face" indicating indifference or lack of understanding of value. As the state examples presented in this article demonstrate, one of the strengths of early childhood experts is in creating and nurturing relationships with decision makers. These relationships are essential; it is through them that those who make decisions will value the message that investing early is the best investment for the future.

Just as there is a developmental trajectory for child development, there are also critical and sensitive periods for the creation of public policy. Windows of opportunity open during the least imaginable times, such as in Louisiana after Hurricane Katrina, and advocates can maximize these situations to promote early childhood policy.

In addition to relationships and timing, early childhood professionals have a powerful arsenal of compelling research about the influence of the early years in building a strong foundation for healthy and productive lives. This information must be shared with those in other fields, in ways they can understand; information can be a powerful tool in the current policy environment, which demands evidence, data, and research. Most policymakers lack understanding about the science of early childhood and brain development and the impact on later life success. Most also do not understand the domino effect of negative life events resulting from lack of nurturing relationships. Policymakers do understand cost/benefit and return on investment, and they usually welcome sound scientific evidence about which investments offer the greatest potential value.

This article demonstrates how the strengths of professionals in the early childhood field can be effective tools in shaping public policy, with inspiring examples from Florida, Louisiana, and Minnesota. Many aspects of policy development are unique to each state, but in each of these states, early childhood advocates used similar strategies: (a) building key relationships, (b) seizing the moment at critical windows of opportunity, and (c) harnessing the power of a few committed individuals who birthed an idea, nurtured it with devotion and attention, and helped create effective public policies to benefit the social–emotional development of young children. In Florida, key relationships were leveraged with legislators and the windows of opportunity were opened through work by ZERO TO THREE Fellows. In Louisiana, the opportunity of new monies flowing into the state following the devastation of Hurricane Katrina was seized to focus attention on the unmet emotional and developmental needs of young children. And in Minnesota, the synergy and momentum of the advances in brain research were parlayed with timing, and key relationships to build systems of care around infant mental health (IMH).

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FSU Harris Infant Mental Health Training Institute has trained almost 200 IMH therapists in infant mental health.

In addition, the work in these three states benefited from the strategic support of the Irving Harris Foundation ("the Foundation") that has continued to encourage Professional Development Network sites to infuse IMH into state policy and the emerging early childhood systems. The Foundation has also supported advocacy training and federal policy work through the ZERO TO THREE Policy Center.

Florida: Building Key Relationships

The Sunshine State provides a poignant illustration of how relationships and critical timing can move public policy forward. In the early 2000, several key leaders in Florida were chosen for ZERO TO THREE Fellowships, which exposed them to icons in early childhood andIMH. The excitement and potential of the emerging brain science inspired a cascade of events from "neurons to neighborhoods," providing impetus to build an IMH system in Florida. Each step of the process—the vision, the planning, and the implementation—was perceptively nourished by professional and personal relationships. It was the classic small group of colleagues "drawing on a napkin" over dinner in 2000 that conceived the statewide Florida Association for Infant Mental Health, building on professional relationships to create a network of almost 1,000 members, now a decade later with 19 local chapters from Key West to Pensacola, all dedicated to a common vision. The vision culminated into Florida's Strategic Plan for Infant Mental Health in 2001, providing a roadmap for infusing IMH into all the early childhood systems, not only in Florida, but many states used to guide their early efforts

Likewise, relationships were pivotal building blocks for each piece of Florida's IMH system. The funding for the original IMH demonstration pilots was a result of asking a local senator to visit an early intervention program in his district, then "educating" him about IMH in conversations and with articles. A few years later, when he became senate president, the relationship made it easy to "make the ask" for funding for an IMH pilot in his Sarasota district and two other key legislators' districts, Pensacola and Miami from 2000 to 2003. The 3-year IMH pilot data showed promising results (Osofsky et al., 2007), which inspired the evolution of the nation's first court team by a ZERO TO THREE Fellow, a judge who became one of the most vocal and ardent converts on the healing transformative power of IMH services. Relationships with a world-renowned clinical psychologist and early intervention experts created synergy for promoting IMH in the courtroom and were the basis of the widely acclaimed DVD *Helping Babies From the Bench* in 2007, which connected the science of early childhood development and evidence-based therapeutic interventions to create a multidisciplinary court team. The Miami Child Well-Being Court Model has been the basis for the inspiration for many replications across the nation, including ZERO TO THREE's Safe Babies Court Teams. Collaborative relationships are the cornerstone in bringing together opposing parties in the courtroom

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Louisiana Mental Health Consultation Program for Child Care Centers offers consultation to assist teachers in managing challenging behaviors, to create supportive environments for children, and to work with families.

toward a shared goal of improving the parent–child relationship. The model has shown over and over again that "attachment promoting parenting" can be fostered in even the most troubled parents with profound benefits for both parent and child.

Building a system of care requires a trained workforce, but, like many other states in 2000, Florida did not have trained clinical therapists to provide IMH. As in other parts of the system development, relationships were key to building a workforce of IMH therapists. Florida State University (FSU), which had a national reputation for training, asked several ZERO TO THREE Board members to help them develop clinical IMH expertise in Florida. Together they went to a private foundation known for IMH training, and they requested and obtained funding that involved a collaboration with the Louisiana State University Health Sciences Harris Program for Infant Mental Health for IMH clinical training to support the development of the FSU Harris Infant Mental Health Training Institute. Florida leveraged these generous foundation monies with state match dollars in 2004 and the Institute has now trained almost 200 IMH therapists in the rigorous 10-month training class, with continuing specialized training in child–parent psychotherapy. Many of the graduates are now in leadership positions throughout the state. Some of the graduates who were in administrative positions in Medicaid, child welfare, and early intervention paved the way for policy changes in their respective state agencies as they were able to cross-walk components of IMH to the appropriate funding strategies. Especially notable were the relationships that enabled a small group of persuasive IMH advocates and innovative policymakers in Medicaid to change the rules to utilize the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (*DC:0-3R*; ZERO TO THREE, 2005) and to allow "parent AND child treatment," which in 2003 opened the door to funding for dyadic IMH work.

In addition, a network of multidisciplinary relationships made possible extensive training conducted across the state to infuse IMH principles across systems (e.g., training for home visitors, maternal and child health providers, child care and child welfare workers, probation officers, early interventionists, and judges). Based on a survey of national experts and colleagues, a comprehensive list of IMH therapists competencies was published, providing a valuable framework for professional development for IMH clinicians (Quay, Hogan, & Donahue, 2009). Professional relationships, policy relationships, and mentoring opportunities all played key roles in building the system. Florida's policy advances grew out of relationships and the commitment of a few dedicated leaders at critical "touchpoints." As Margaret Mead taught, "Never doubt the power of a small group of committed people to change the world. In fact, it is the only thing that ever has. (Applewhite, Evans, & Frothingham, 1992, p. xvi).

Louisiana: Seizing Opportunities

Louisiana has an extraordinary developmental sequence in creating a truly comprehensive early childhood system (health, mental health, early care and education, family support and parenting education, and child safety) that supports infant and early childhood mental health. Like Florida, Louisiana's sequence depended on key relationships and critical windows of opportunity. The Chinese proverb about disaster being an opportunity was aptly illustrated in how the Louisiana advocates seized the opportunities and funding after Hurricane Katrina to build a comprehensive early childhood system.

Louisiana was exceptionally effective in utilizing federal monies from the State Early Childhood Comprehensive Systems grant program administered by the U.S. Department of Health and Human Services, Maternal and Child Health Bureau. Beginning in 2003, small, noncompetitive Early Childhood Comprehensive Systems grants were made available to each state's Maternal and Child Health program; the original funding level was $100,000 per state. Louisiana used its grant to build a comprehensive system by focusing simultaneously on infrastructure and services. Louisiana called this initiative BrightStart, with a primary goal to develop, support, and maintain systems integration and partnerships to enhance children's ability to enter school healthy and ready to learn.

In 2003, the Louisiana Maternal and Child Health program and the Governor's Office contracted with the policy branch of Tulane University Institute of Infant and Early Childhood Mental Health (Institute), supported by the Irving Harris Foundation, to coordinate BrightStart. The Institute has an impressive history of informing and influencing early childhood policy through the application of established research findings and best practices from across the country. The Institute provided "continuity of care" to ensure a consistent and sustained focus on the social–emotional and mental health needs of infants and toddlers through the adoption of both state legislation and policies. Four of the key changes in their system that support infant mental health are highlighted below: Early Childhood System Integration Budget; Quality Rating and Improvement System; Social-Emotional Subscale of the Environment Rating Scales; and Mental Health Consultation to Child Care Centers.

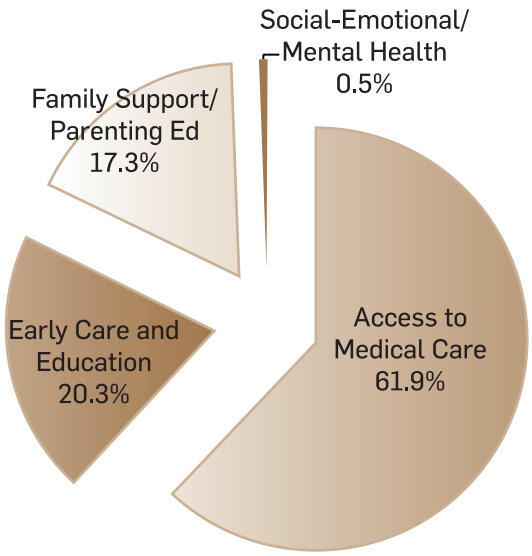
Early Childhood System Integration Budget

The essential starting point to building an early childhood system is understanding the budget resources allocated to early childhood. Every advocate and policymaker should ask the basic question, "How much money are we spending, and on what programs, to prepare children for school?" Overall, access to budgets allows policymakers, state leaders, and advocates to examine the adequacy of funding in policy priority areas and identify both opportunities for enhanced collaboration and areas ideal for the blending and/or braiding of funds.

BrightStart and the Institute developed the conceptual framework for the Early Childhood Budget based on other work done on children's budgets from around the country (Hayes & Szekely, 2007; Johnson & McBrayer, 2003). Meetings with key leaders in the governor's office and the state budget office were requested by different groups depending upon the relationships that existed. The concept for this budgeting tool was quickly embraced. The legislature ultimately supported the creation of the Early Childhood Budget through legislation passed by both chambers unanimously and signed by the governor on August 15, 2008.

The Early Childhood Budget has now successfully provided a detailed understanding of the investments the state is making in early childhood for the past 3 years. As summarized in Figure 1, the bulk of the money is currently in the medical category (62%), with very little being spent to support the social–emotional/mental health needs of young children (0.5%). The budget integration has served as a tool to both nurture collaboration and provide an "at-a glance" overview for early childhood policymakers and advocates of how resources are invested toward early childhood.

Figure 1. The Louisiana Early Childhood Systems Integration Budget for FY 2011–2012 as Appropriated July 1, 2011



Quality Rating and Improvement System

Louisiana has an impressive cadre of experts who have invested decades in promoting IMH. These experts' vision, their key relationships, and their ability to "be at the right place at the right time" created the perfect combination for successfully infusing IMH into the quality rating system for child care. Louisiana has created an exemplary quality rating and improvement system (QRIS) with a strong emphasis on the social–emotional development of children, an innovative tax incentive for excellence, and a support system for mental health consultation to child care centers. The opportunity to design and implement the QRIS presented itself in large part in the wake of Hurricanes Katrina and Rita in 2005. With this opportunity, the question from key state leaders who had trusting relationships with the Institute was not, "Should we build a QRIS?" but "How fast can we build a QRIS?" The innovation that became the hallmark of the Louisiana QRIS was its intentional focus on social and emotional development.

Social-Emotional Subscale of the Environment Rating Scales

The QRIS in Louisiana uses the Environment Rating Scales (Harms, Clifford, & Cryer, 2005; Harms, Cryer & Clifford, 2006) as a key component for centers to earn points that translate into stars, but the critical piece for most quality centers is the score on the newly created Social-Emotional Subscale (SE Subscale). In most instances, the SE Subscale score is used as part of the criteria to determine the star rating. Over the past 3 years, scores on the SE Subscale have increased on average 0.91 points on a 7-point scale and average 0.5 points higher than the overall score. More important than the actual score, the SE Subscale score reinforces the focus and attention of the system on the social and emotional needs of young children.

Mental Health Consultation to Child Care Centers

A primary quality support initiative designed as part of the implementation of the QRIS is the Louisiana Mental Health Consultation Program for Child Care Centers. Consultations are available to centers participating in the QRIS, to assist teachers in managing challenging behaviors, to create supportive environments for children, and to work with families. The Institute developed and implemented this program for the state, which now has 11 mental health consultants (MHC) working statewide and who serve approximately 80 centers at any one time. The MHCs are licensed mental health professionals who all have been trained in IMH.

Social–Emotional Screening in Child Care Centers

One of the ways to earn points in the QRIS is to monitor children's social and emotional development actively. The Louisiana QRIS model states that centers are to "complete screening for social-emotional development with an instrument from the recommended list for all children (from birth to 5 years of age) within 45 calendar days of enrollment and annually thereafter"(Quality Start Child Care Rating System Model, 2012). The MHCs offer this needed training across the state several times each year in each region. In addition, the MHCs maintain a "Warm Line" for centers using social–emotional screening tools to call to request more specific assistance.

To support the Louisiana QRIS, BrightStart, the Institute, and many child advocates worked for the passage of the School Readiness Tax Credits, a unique package of tax credits to support quality child care through incentives to families, providers, child care professionals, and businesses. These credits were passed by the Louisiana state legislature in 2007 and went into effect January 1, 2008. Over the 3 years of implementation, the School Readiness Tax Credits have grown from an overall impact of $4.2 million to $11.2 million, an increase of 166%. These additional dollars into the child care sector are critical to help centers build and sustain their quality. These tax benefits will continue to grow as quality grows in each subsequent year.

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The sustained commitment to infant mental health in Minnesota has assisted the Minnesota Department of Human Services to develop the clinical capacity to provide interventions to children less than 5 years old and their families.

Learn More

Florida Association for Infant Mental Health
www.faimh.org

Louisiana BrightStart
www.brightstartla.org

Minnesota Early Childhood Mental Health
www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_149096#

ZERO TO THREE Policy Center
www.zerotothree.org/policy

Making It Happen: Overcoming Barriers to Providing Infant-Early Childhood Mental Health
This new resource highlights the scientific evidence for infant-early childhood mental health (I-ECMH) policies; examines issues faced by national, state, and local program directors and mental health practitioners in providing I-ECMH services; and proposes a set of recommendations for policy improvements at the federal level. In addition, it provides a context for the issues and barriers states face when financing services for those most in need during a time of life when those services would have the highest rate of return. Available at www.zerotothree.org/makingithappen

Minnesota: From Science Research to Policy Outcome

Minnesota's work on IMH spans nearly four decades. Beginning in the 1970s, the groundbreaking University of Minnesota Longitudinal Study began investigating the role of early experience in development. This research illuminated the importance of secure attachment as a protective factor in the development of children in high risk families. Recent advances in behavioral science and neuroscience have added compelling evidence for investment in early childhood across the nation. Years of promoting this evidence, educating policymakers, foundations, and the local community and nurturing key relationships have profoundly influenced Minnesota's early childhood policies and practices.

Based on findings from the longitudinal study, Steps toward Effective, Enjoyable Parenting (STEEP) was developed by the mid-1980s. STEEP shifted parent–infant services toward a greater emphasis on IMH, parental mental health, and the importance of relationship-based service and reflective practice. The findings of STEEP influenced home visiting programs in Minnesota (and elsewhere); the adaptation of STEEP strategies into other home visiting efforts contributed to policy changes that have expanded and enhanced home visiting services for high risk parents and infants since the 1990s.

Over the past 15 years, Minnesota has benefited from Foundation support that has enhanced research in child development, disseminated early childhood best practices, educated the future early childhood work force, and informed policy development and best practices throughout the state. These efforts led to a growing recognition of the need for deeper and more sustained training to prepare frontline workers such as nurses and parent educators to address the mental health needs of infants and families. A second path emerged simultaneously: the need to prepare mental health professionals to extend their skills to infants and their parents, as well as to offer mental health consultation to other professionals who often first see the developmental challenges in these young families. As a result, the University of Minnesota, with support from the Foundation, local foundations, and the early childhood community, developed the Infant and Early Childhood Mental Health Certificate Program at the University of Minnesota, and the first cohort of the certificate program began in Fall 2007. The University of Minnesota, along with other local partners, also lent resources and support to assist the Children's Mental Health Division of the Minnesota Department of Human Services to develop the clinical capacity to provide interventions to children less than 5 years old and their families. The Minnesota Children's Mental Health Division built relationships with the provider community to disseminate clinical evidence-based practices while simultaneously aligning policies to better ensure that families who have children with mental health conditions have access to the highest quality of care. Efforts are focused on increasing access, quality, and capacity for care of children from birth to 5 years old with mental health conditions.

To this end, beginning in 2005 and through a partnership with the Minnesota Department of Health, more than 1,000 licensed clinicians were trained in the use of the *DC: 0-3R* (ZERO TO THREE, 2005). To support clinicians using the *DC: 0-3R*, a monthly consultation group was created using interactive television capacity so that clinicians do not need to travel long distances to receive information and share knowledge.

The robust IMH work history within the state of Minnesota and the current policy and system development occurring within the Children's Mental Health Division exemplify the importance of fostering partnerships and relationships, and using them to link research to training and to the development and dissemination of sound interventions to best serve young children and their families.

Conclusion

It has never been easy to change the course of state policy to increase investments and attention on infants, young children, and families. In the current political and economic climate, it is almost impossible. According to some reports, 30 states have projected or have addressed shortfalls totaling $49 billion for the upcoming fiscal year (Center on Budget and Policy Priorities, 2012). And at the federal level, the U.S. House of Representatives and the U.S. Senate cannot reach agreement on budget appropriations for programs of acute importance to infants, young children, and families. To alter the trajectory of public policy, early childhood development professionals and advocates must hone skills in nurturing relationships with decision makers, recognizing and seizing windows of opportunity, and articulating the science of early development—as well as build advocacy skills and enlist many more advocates to take action.

These are valuable strategies for advancing IMH policy and practice, and ones that other states might adapt. The examples of Florida, Louisiana, and Minnesota are not meant as models that can be replicated, because every policy situation has its own context, but they do validate that an intentional focus on achieving these policy outcomes can have considerable success.

While professionals in the field continue to advance the IMH knowledge base and create, test, and implement more effective IMH interventions, they must also promote advocacy efforts to create policies that support the inclusion of IMH in early childhood systems. Infusing IMH into early childhood systems is a real and viable policy option, but more people must be willing to talk and advocate in the policy arena. Ultimately, the options are only limited by the belief in what is viable and achievable and by how many advocates are out there pushing for these policies.

Mimi Graham, *EdD, has been director of the Florida State University (FSU) Center for Prevention and Early Intervention Policy since 1993, specializing in policy, training, and special projects for vulnerable infants and toddlers. FSU had one of the original federal Healthy Start grants, which inspired the development of the widely used* Partners for a Healthy Baby Curricular Series. *Dr. Graham provides leadership and oversight for a variety of projects at FSU Center including: Florida's Fussy Baby Network, The Harris Infant Mental Health Training Institute, FSU's Early Head Start, Young Parent Project, Child Welfare Community Collaboration, and the Partners for a Healthy Baby Home Visiting Training Institute. She is a cofounder of the Florida Association for Infant Mental Health and a Fellow in ZERO TO THREE and Florida's Policy Group for Children & Families. Previously, Dr. Graham was principal of the University of Miami Debbie School and education director of the Infant Health and Development, a successful national intervention for low birth-weight babies. She has two teenagers that help her appreciate early childhood.*

Geoffrey A. Nagle, *PhD, LCSW, MPH, is the director of the Tulane University Institute of Infant and Early Childhood Mental Health and an associate professor of psychiatry at the Tulane University School of Medicine. Geoff has made numerous presentations around the country on topics including building an early childhood system, designing a state early childhood budget, and the economic impact of child care. His research interests are in the economic benefits of prevention and how the results of research in early childhood influence public policy decisions.*

Catherine Wright, *MS, is a licensed professional clinical counselor (LPCC) and the early childhood mental health system coordinator within the Children's Mental Health Division of the Department of Human Services for the State of Minnesota. At the State of Minnesota, Catherine is responsible for developing the early childhood mental health system of care, including arranging for and managing trainings in evidence-based practices for early childhood mental health clinicians, supporting policy development around early childhood mental health, and integrating clinical services within family serving systems such as child care, Head Start, schools, primary care clinics, and the adult mental health system. Catherine has 20 years of experience providing direct children's mental health services and managing children's mental health programs and systems. Catherine has a master's degree in counseling psychology from Northeastern University and is currently obtaining her doctorate in counseling psychology from the University of St. Thomas.*

Cindy Oser, *RN, MS, is senior policy strategist at ZERO TO THREE Policy Center. Ms. Oser has more than 30 years of experience in pediatric nursing, public health, early intervention for infants and toddlers with disabilities, and early childhood policy. Ms. Oser has been with ZERO TO THREE since 1998 in a variety of roles. She is the author of many publications, including* America's Babies: The ZERO TO THREE Policy Center Data Book *(2003) and most recently* Making It Happen: Overcoming Barriers to Providing Infant-Early Childhood Mental Health *(2012). Prior to joining ZERO TO THREE, she served as chief of the Bureau of Early Intervention Services at the Ohio Department of Health. Ms. Oser served as the first president and founding board member of the IDEA Infant Toddler Coordinators Association and served on the national board of the Division for Early Childhood, Council for Exceptional Children from 2008 to 2011.*

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Infusing Mental Health Services Into Primary Care for Very Young Children and Their Families

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At her son's 6-month well-child visit, Mrs. Martin is fully engaged with the pediatric clinician, answering all his questions and listening carefully to what he says. And the baby, Glenn, appears interested in his surroundings, calm and well regulated. Yet as the visit ends, the mother says quietly, "we can't get him to eat." She explains that she and her husband have been trying to get Glenn to eat solid food for about 4 weeks and he just "purses his lips and refuses the food on the spoon." After a lengthy discussion of the mechanisms of feeding: size of the spoon, consistency of the food, number of formula bottles he takes, and his current weight, which is appropriate for his age, the pediatric clinician seems to be running out of options for the conversation.

At no time during this lengthy conversation does Mrs. Martin ever glance at, acknowledge, or hold Glenn. Rather he is in his infant seat on the floor beside her chair. Near the end of this 10 minute conversation, he starts to fuss; Mrs. Martin silently picks him up and he immediately arches his back away from her body and looks off into space. As the pediatric clinician completes the visit with gentle reassurance the "he just needs to practice more and drink fewer bottles," not once have mother and son looked at each other nor has the mother tried any techniques to soothe him or help him adjust to her body as she holds him.

Later, as the clinician recalls the visit, he feels uncomfortable but he can't put his finger on what he might be missing or why he is so uneasy about this young family.

For many families with very young children, the pediatric well-child visit is the place to go to get information and support on raising their new baby. Pediatric primary care is accessible, offering evening and weekend hours; universally available given new health care regulations; and, perhaps most important, has no entrance criteria. All families are eligible for services and receive the same pediatric services whether it is a family with a teen mom, a neonatal intensive care unit baby, a first-time mom, or parents who are in recovery from addiction. Most families eagerly take their baby to their pediatric clinician (e.g., pediatrician, pediatric nurse practitioner, family medicine physician); in fact, taking the baby to the doctor is one way to feel and to be seen as a "good parent." In this way pediatric well-child care is nonstigmatizing; instead of walking in the door of the mental health clinic or failure-to-thrive program, the pediatric clinician's office is about wellness and the celebration of milestones achieved by the baby. This is the power and magic of pediatric primary care: to support parents in their child rearing, to validate parents' ideas and concerns, and, in some cases, to facilitate changes in parental behavior (Lerner & Ciervo, 2010).

Pediatric care offers a window of opportunity for families with new babies. The birth of a baby brings many changes to the lives of the parents—new routines, new roles in the family, new equipment to manage, perhaps new housing or different employment status. Even before the baby is born many families make changes to accommodate the new life by quitting smoking, changing diet, or finding more stable employment to provide for the family. Change is the metaphor for the first year of life with a newborn, both for the baby

Abstract

Thinking beyond physical health to include mental health and emotional well-being offers the pediatric clinician different approaches to old challenges and a new lens through which to view infant and parent behavior. Because pediatric primary care is accessible, universally available, has no entrance criteria, and is nonstigmatizing, clinicians often serve as first responders for families in distress. Funding from the Irving Harris Foundation supports training of early childhood clinicians to work in primary care. These early childhood professionals create access to behavioral health services for populations that often face challenges and barriers when trying to access community resources.

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For many families with very young children, the pediatric well-child visit is the place to go to get information and support on raising their new baby.

and for her parents. The pediatric clinician can be a powerful ally in identifying and supporting changes which the family makes for their new baby.

The timing and frequency of those early well-child visits create the foundation for building a trusting relationship between the pediatric clinician and the family. Pediatric clinicians have an initial built-in trust factor ("the doctor says...") which can help parents identify changes they need to make to ensure the health and well-being of their new baby. And finally, pediatric clinicians are often the only professionals to interact with the family around this new baby, to have "eyes on" how the baby is growing and developing well into the preschool years, and to keep track of family dynamics and relationship development. Although families are often unable to locate, afford, or obtain a voucher for child care for their infants and young children, health care legislation has made it possible for the vast majority of families to access pediatric primary care services.

Why Infuse Mental Health Issues Into Pediatric Practice?

The hallmark of pediatric practice is anticipatory guidance, which includes conveying information that assists parents in understanding current and future developmentally salient issues with the hope of preventing future disturbance. Recommended topics include injury and violence prevention, sleep issues, nutritional counseling, and fostering optimal development. The American Academy of Pediatrics' Bright Futures Task Force, a national health promotion and disease prevention initiative, highlights parental well-being; infant behavior, growth, and development; and parent–child relationship issues as salient factors for pediatric clinicians to address during well-child visits in the first year of life (Hagan, Shaw, & Duncan, 2008).

The pediatric primary care environment is ideally suited to emphasize both physical and mental health. After the birth of a baby, in which medical personnel have asked about and observed an intimate family experience like childbirth, there is often less resistance to answer when the pediatric clinician asks if a parent has been feeling sad or blue during the past 2 weeks or if the mother feels safe in her home.

Upon reflection, Glenn Martin's pediatric clinician states that he completed the visit feeling helpless; he had no more advice to give. When the baby's posturing and emotional behavior are recalled, he begins to think about what the baby might be trying to tell him—is his sensory system challenged by being held?; Is he unaccustomed to physical interaction from his caregivers?; Is he on the autism spectrum?; Or is the mom feeling isolated, anxious about feeding him? After all, what "good" mother cannot feed her child? Is she stressed? Is she depressed? Is there verbal or physical abuse occurring in the home? Is she being pressured by extended family to feed him before he is ready or to feed him foods he isn't ready to eat?

Although considering the mental health implications of the feeding worries described by Mrs. Martin does not give him the answer to why Glenn refuses solid food, it does give the pediatric clinician new avenues of inquiry and approaches to the concern raised by the mother.

Thinking beyond physical health to include mental health and emotional well-being offers the pediatric clinician both different approaches to old challenges and a new lens through which to view child and parent behavior. Funding from the Irving Harris Foundation (Foundation) supports training of early childhood professionals to work in pediatric primary care settings. These early childhood professionals create access to behavioral health services in a setting where access to such care is often limited and for populations that often face challenges and barriers when trying to access community resources. Beyond providing direct services, early childhood professionals who work as an integrated team with pediatric clinicians in primary care settings function as reminders of early childhood and family mental health, providing education and guidance to pediatric primary care clinicians and, consequently, enhancing the quality of care patients receive (Talmi, Stafford, & Buchholz, 2009). As part of the Foundation's Professional Development Network (PDN), Boston University School of Medicine has supported pediatric faculty who provide training in infant mental health to more than 42 pediatric residents per year during their monthly developmental and behavioral rotation. Faculty also teach and supervise developmental and behavioral pediatric fellows in their work with very young children and their families. At the University of Colorado School of Medicine, PDN funding allows for training of more than 150 pediatric health professionals and between four and six early childhood mental health clinicians working in the context of pediatric primary care through the Colorado Harris Program. Faculty of this program teach and supervise pediatric residents, physician's assistant trainees, medical students, and other health professionals rotating through the pediatric clinic.

Mental Health Concerns in Young Children

In the last decade, understanding about the complexity of factors that can impact healthy child and family development has surged. Some critical lessons have come from the work on adverse childhood experiences and the long-term outcomes which can result from such adverse experiences as emotional, physical, and sexual abuse; household substance abuse; parental mental illness; incarceration; and parental domestic violence, separation, or divorce. This significant body of research (Bair-Merritt, Blackstone, & Feudtner, 2006; Dube et al., 2001) has fostered renewed interest in the concept of "toxic stress" and ongoing research into an ecobiodevelopmental framework that illustrates how early experiences and environmental influences can leave a lasting signature on the genetic predispositions that affect emerging brain

architecture and long-term health (Shonkoff et al., 2012). In particular situations, for example after the birth of a preterm infant, research has shown that maternal grief resolution impacts the quality of attachment security and emphasizes the critical role of clinicians in supporting grief resolution and improving the quality of maternal interaction (Shah, Clements, & Poehlmann, 2011). This paradigm truly shifts the role of the pediatric clinician to not just anticipating child development but preventing distress or disorder and impacting lifelong health and development.

The PDN supports the training of pediatric clinicians to identify children with such mental health concerns as autism, extreme impulsivity, and depression. By working closely with or participating in case conferences with early childhood mental health clinicians, pediatric clinicians are introduced to a different way of thinking about child behavior and parent–child relationships. PDN funding provides opportunities for cross-disciplinary training of primary care pediatric clinicians to screen and refer even very young children with mental health concerns.

Models That Successfully Infuse Mental Health Into Pediatric Primary Care

There are several models currently infusing maternal and infant mental health perspectives and services into primary care including Healthy Steps for Young Children, Project DULCE, and Fussy Baby.

Healthy Steps for Young Children

In the pediatric primary care setting, families are afforded a layer of protection and confidentiality in which they can explore their worries, concerns, and delights about their child, themselves, and their role as parents. After the birth of a new baby, the infant and family are in a dynamic state of flux. New parents are often receptive to professional information, guidance, and support to help them cope with the demands of new parenthood. Pediatric care for young children offers a powerful vehicle to infuse mental health services into an ongoing system of care (Zeanah & Gleason, 2009). Although pediatric practices may not recognize or feel the potential power they have to influence a child's outcome, they create an unparalleled, nonstigmatizing environment from which to offer families information and support about their child's social–emotional well-being and about their growth as a family (Zuckerman, Kaplan-Sanoff, Parker, & Young, 1997).

The Healthy Steps for Young Children program is a national initiative that emphasizes a close relationship between pediatric clinicians and parents in addressing the physical, emotional, and intellectual growth and development of children from birth to 3 years old (Kaplan-Sanoff, 2001; Zuckerman, Parker, Kaplan-Sanoff, Augustyn, & Barth, 2004). Developed more than 15 years ago as an approach to provide developmental information and parenting support through primary care pediatrics for all families with infants and young children, Healthy Steps is now a recognized evidence-based model of care, designated by the Substance Abuse and Mental Health Services Administration and the Affordable Care Act Maternal Infant Early Childhood Home Visiting (MIECHV) program as one of several approved for federal funding. In addition it has been shown to substantially increase clinician and trainee ratings of their preparedness to deliver behavioral and developmental care and increased the ratings of the quality of care provided (Randolph et al., 2011).

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The birth of a baby brings many changes to the lives of the parents—new routines, new roles in the family, new equipment to manage, perhaps new housing or different employment status.

In a traditional pediatric practice, one pediatric clinician typically tries to address all of the child's health and developmental needs. Healthy Steps expands the model of a solo pediatric clinician to include a new member to the health care team—the Healthy Steps specialist who enhances the information and services available to parents. The Healthy Steps specialist can be a new team member or a nurse, child development specialist, or social worker already working in the practice. Healthy Steps specialists are trained in child development, early intervention, child care, social work, counseling, or nursing to address major behavioral and developmental issues, focusing on the child within the context of the family (Kaplan-Sanoff, Lerner, & Bernard, 2000). In a recent study, families participating in the Healthy Steps Program in Colorado were more likely to have the following developmental topics addressed during primary care visits than those families not participating in the program: language development, social skills, importance of play, daily routines, sleep, healthy eating, temperament, parent feelings including postpartum depression, home safety, and breastfeeding (Buchholz & Talmi, 2012).

Healthy Steps helped parents better understand their child's behavior and development, thereby producing more favorable disciplinary practices. In the *JAMA* 2003 report (Minkovitz et al.), Healthy Steps mothers enrolled in the national evaluation that had experienced sadness, reported depressive symptoms, or limited their activities because of feeling anxious or depressed, were 1.6 times more likely than mothers not enrolled in Healthy Steps to report that they had discussed feeling sad with someone in their Healthy Steps practice (Minkovitz et al., 2003; Minkovitz et al., 2007). Along with the 5 year follow-up study these findings supported the idea that the pediatric practice can be an effective vehicle for discussing and screening adult mental health concerns (Minkovitz et al. 2007). In Colorado, MIECHV funding is being used to expand the continuum of home visiting programs and create greater access to home visitation services in the first 3 years of life statewide. In addition, Project DULCE: Developmental Understanding and Legal Collaboration for Everyone is funded by The Center for Social Policy Quality

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Thinking beyond physical health to include mental health and emotional well-being offers the pediatric clinician both different approaches to old challenges and a new lens through which to view child and parent behavior.

Improvement Center on Early Childhood (n.d.) using an abbreviated Healthy Steps approach to address the issue of child abuse prevention.

Project DULCE

Many environmental and family stressors contribute to child abuse and neglect. Project DULCE combines two powerful models—Healthy Steps and the Medical Legal Partnership, a program which provides legal advocacy and services for families needing assistance with nutritional benefits, housing supports, electricity and heat shut-off protection, and educational placement for children with special needs to prevent the parental stress often associated with child abuse. It has never been more important for pediatricians, child development specialists, and legal advocates to engage in structured collaboration on behalf of vulnerable children who continue to experience barriers to care and barriers to services that in many instances could be eliminated through legal advocacy. There is greater acknowledgment of the role of social needs in determining a child's health status, as reflected in one study which found that 85% of clinicians believe that unmet social needs are leading directly to worse health for all Americans (Robert Wood Johnson Foundation, 2011). Indeed, health reform efforts such as MIECHV are shining a spotlight on harmful, population-level health and service disparities that, through a legal lens, can be understood as a profound civil rights issue.

Project DULCE is a randomized control trial recruiting all families with newborns who are receiving their pediatric well-child care at Boston Medical Center with the exception of significantly premature babies and those with Narcotic Abstinence Syndrome. Project DULCE has two primary goals: (a) helping parents understand their newborn's behavior through providing child development information specific to their child and (b) reducing maltreatment by addressing the risk factors which many families bring to parenting. The Project DULCE intervention aims to promote positive parenting while reducing family risk factors and, in so doing, increase resilience, resulting in more optimal child development, and reducing maltreatment. Project DULCE focuses on supporting six family protective factors:

1. Parental resilience: a parent's ability to bounce back from difficulties
2. Social connections: a network of informal or formal supports, for example, friends, family, faith group
3. Concrete supports: knowing where to turn for help and how to help, for example, identifying and accessing programs to help with food, housing, utilities, or child care
4. Knowledge of parenting and child development: parents know how children grow, what behaviors are appropriate at a given age
5. Social and emotional competence of children: children learn to talk about and handle feelings
6. Attachment: understanding appropriate emotional and behavioral relationships between children and familiar adults

Conclusion

Child development and infant mental health specialists have a unique opportunity to engage in preventative, universal efforts in the context of pediatric primary care settings. Lessons learned from Healthy Steps and Project DULCE, sites can provide suggestions on how infant mental health professionals can augment the role of primary care pediatricians to support families as they raise their infants and young children. These suggestions include:

1. Ask about a child's primary care clinician. Families are likely to seek advice and support from their primary care clinicians and often establish close relationships with their pediatricians. These relationships are long-standing and important in the lives of young children. Understanding the relationship between a family and a health care clinician offers information about the resources and supports available to families. For example, some pediatric clinicians conduct routine developmental and social–emotional screening. This information is often useful to both parents and early childhood professionals in understanding a child's current functioning and needs.
2. Get to know primary care clinicians in the community. When primary care clinicians are familiar with early childhood professionals, they are more likely to refer and utilize their services appropriately. As described by one pediatrician: "Now I can put a face to a referral program and have more confidence in my referral working for the family." Providing information and resources to pediatric practices improves communication between systems of care that are central in the lives of young children.
3. Obtain permission from families to share information with primary care clinicians. Communication among different providers is essential in creating medical homes

Learn More

Bright Futures
http://brightfutures.aap.org/index.html.

For additional information on medical homes see
www.cdphe.state.co.us/ps/hcp/medicalhome/index.html
www.medicalhomeinfo.org/

for young children. With consent from families, early childhood professionals can establish bi-directional communication with primary care clinicians in order to coordinate services, understand clinical presentations, and offer targeted support to young children and their families.

4. Help families find suitable primary care clinicians. Having a medical home is important for healthy development. For families who have not established a relationship with a consistent primary care clinician, early childhood professionals can help identify clinicians who would meet the needs of young children. Ideally, primary care practices would use standardized developmental screenings, including screening for social–emotional and family issues, and would offer comprehensive services that are culturally responsive and in the family's language of choice.

Connection to the health care system is critical in providing comprehensive services to young children and in fostering family-centered medical homes. Early childhood professionals (e.g., infant mental health specialists, Healthy Steps specialists, Fussy Baby specialists) working within pediatric primary care settings provide high-quality care to young children and their families and collaborate closely with pediatric clinicians to ensure that families' needs are met. Support from the PDN has allowed an expansion of cross-disciplinary training opportunities for primary care pediatric clinicians. Such interprofessional education and cross-training ultimately functions to transform the way health services are delivered by establishing integrated, coordinated, and comprehensive practices. Finally, for vulnerable young children and their families, identifying pediatric clinicians who can offer comprehensive services, including standardized developmental screening, social–emotional screening, and family support, strengthens the resources and supports available to families as they navigate complex systems of care.

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Topics in Infant Mental Health Research

The Professional Development Network shares news and information about research, policy, and practice innovations in their work with infants, toddlers, and families.

Researching Infant Mental Health Practice and Practicing Infant Mental Health Research

Jon Korfmacher, Erikson Institute

As is true of any field that has the term *mental health* in its title, infant mental health exists largely in a clinical realm. To be a mental health specialist often assumes the provision of services focused on social and emotional well-being, in this case to young children and their families.

It is less often that mental health specialists think about infant mental health research. But it exists. There is, for example, the *Infant Mental Health Journal*, with its many research articles spread over 33 volumes. There are also multiple handbooks of infant mental health that summarize the empirical support for its core principles (Osofsky & Fitzgerald, 2000; Zeanah, 2009). Further evidence supporting the existence of infant mental health research can be found in evidence-based treatments with explicit infant mental health frameworks that have demonstrated value through the gold standard of randomized controlled trials, with Child-Parent Psychotherapy (CPP) as one prominent example (Van Horn et al., this issue, p. 48). Infant mental health research exists in different forms. There is the basic research that provides support to infant mental health principles, such as the multitude of studies focused on attachment and the importance of parental sensitivity and mindfulness in the parent–child relationship (Mayes, Rutherford, Suchman, & Close, this issue, p. 83). There is also applied research that takes concepts of infant mental health and examines how they might be manifest in the "real world." An example of this is presented in the current issue with Tracy Moran and her colleagues (Moran, Franklin, Troutman, & Evenson, p. 80), reporting on the process of developing a developmentally sensitive self-report tool on parent efficacy. Finally, there are studies that seek to understand and validate infant mental health services. These are program evaluations or clinical trials of treatment strategies, such as those conducted with CPP.

All of these types of research have a healthy representation within the infant mental health field. And yet infant mental health is rarely thought of as having an empirical base. Instead, the field is typically represented in clinical case studies that present ideas through metaphors, such as ghosts, angels, and 2-year-olds who bring their mothers to therapy (Fraiberg, Adelson, & Shapiro, 1975; Harmon et al., 1990; Lieberman, Padrón, Van Horn, & Harris, 2005). Infant mental health often seems to be insight-driven, not data-driven.

DEFINING INFANT MENTAL HEALTH

It is important to consider why it is so difficult to focus on mental health research. I would argue that one major issue is definitional. There is a lack of clarity regarding what is meant by infant mental health. From a research point of view, it is hard to study what one cannot define, and infant mental health is dealing with principles that are hard to define.

The basic definition of infant mental health itself is one place to start. Definitions have evolved over time and for different purposes (Osofsky & Thomas, this issue, p. 9). For example, ZERO TO THREE's Infant Mental Health Task Force has developed two definitions in the past decade. The first one (ZERO TO THREE Infant Mental Health Task Force, 2002) noted that infant mental health is

the developing capacity of the child from birth to age three to...

- *Experience, regulate, and express emotions,*
- *Form close and secure relationships, and*
- *Explore the environment and learn*

all in the context of family, community, and cultural expectations for young children. Infant mental health is synonymous with healthy social and emotional development.

Notice that this definition is focused on outcomes. It suggests that infant mental health can be seen in what the infant does, or should do. But there is no mention of what those in the field do to support the infants in their emerging developmental capacities. An updated definition, currently posted on the ZERO TO THREE Web site (n.d.), states that:

"Infant mental health" is defined as the healthy social and emotional development of a child from birth to 3 years; and a growing field of research and practice devoted to the:

- *Promotion of healthy social and emotional development;*
- *Prevention of mental health problems; and*
- *Treatment of the mental health problems of very young children in the context of their families.*

Along with actually mentioning research, this definition has a more explicit acknowledgment of practice—across the spectrum of promotion, prevention, and treatment. But this statement is still ambiguous. For example, specific elements from the first definition (e.g., experiencing, regulating, and expressing emotions) have been replaced with the general concept of "healthy social and emotional development." It is also not clear what an infant mental health specialist does to promote, prevent, and treat mental health issues in young children. The definition still does not tell how to distinguish an "infant mental health" approach.

At the 2012 meeting of the Irving Harris Foundation Professional Development Network (PDN), participants from 16 different program sites discussed how to infuse infant mental health into home visiting, and it became clear that this infusion meant different things to different people. For some, it was helping parents see the perspective of their infant. For others, it was understanding the

parent's history and its contribution to the relationship. For others, it involved not direct work with parents, but the ability to support providers in their work with families—to help them "address, assess, and tolerate" (as one network member put it) mental health issues that families bring, introducing the element of reflective practice that is also often seen as a hallmark of infant mental health work.

Of course, one can make a case that all of these are essential elements of infant mental health practice. But delving further into practice, how can the different skills involved in this work be articulated? How does one operationalize helping a parent take the perspective of their infant? Or tolerating the emotional undercurrents of a helping relationship? Or (to evoke a core concept of CPP) bringing again the feeling to a family that the parent can lovingly protect and keep a child safe from harm?

IMPLEMENTATION SCIENCE

It is here that infant mental health research and its emphasis on defining terms may prove most useful. Although it is important to continue to demonstrate the effectiveness of infant mental health interventions, it is also essential to have a clearer understanding of the components of these effective interventions. This involves more intensive examination of the programs themselves, what goes into the programs, and what happens when a family actually engages in these services. In other words, more attention must be directed to important questions of implementation of infant mental health practice.

Implementation research has been around for decades, even if these studies have not had the same prominence of outcome-based studies that indicate whether an approach "works" or not. This research takes many forms. Sometimes such studies involve intensive review of program records and datasets in order to better understand patterns of service delivery (Damashek, Doughty, Ware, & Silovsky, 2011). Sometimes the study involves surveys or in-depth interviews with parents and service providers about their experience of giving or receiving help (Humphries & Korfmacher, 2012). The metaphor often used (even researchers have metaphors) is "looking inside the black box" (Berlin, 1998). Recently, however, the more serious term *implementation science* has taken hold (Metz & Bartley, 2012).

The current dedication to evidence-based programs within early childhood policy (Powers, 2012,) has led to a concomitant focus on the operation of these programs as they are disseminated beyond the protected habitat of a controlled trial. This approach has led to growing recognition of the need to be much more rigorous in studying the implementation of services and treatments—ranging from the development and application of a program model within a local context, to the training and competence of the workforce, to the fidelity of the services to the model.

Logic models outline the connection between program services and outcomes and have become a de facto element of many program funding proposals. Current implementation science, however, suggests these logic models need be systematically extended to include outside influences or implementation drivers, such as funders, regulatory agencies, and administrative leadership. An example is the work of Anne Duggan, a prominent home visiting researcher, who has developed a model for early childhood home visiting that details these drivers, as well as within-program processes, and their interconnection to the eventual child and family outcomes (Duggan, 2012). Although not necessarily an "infant mental health" model, Duggan's articulation of program and program-related elements is a useful framework for considering infant mental health services.

CPP provides a convenient example to consider these issues. Even though CPP is an evidence-based treatment, there is still much to learn about this treatment strategy. For example, what conditions are necessary within a program for CPP to be implemented effectively? In what ways do learning collaboratives prepare clinicians for using the model, and what further supports are needed? How are eligible families made aware of the availability of these services, and how to they react to a dyadic model that may feel different to implement from other mental health services? What practices within the model of CPP are typically implemented, and how do these treatment elements relate to outcomes? Finally, within the larger service system, how much support is there for a longer-term treatment model such as CPP? Are there issues in reimbursement that may present challenges to its widespread use, particularly for lower-income families who rely on public funding for services? Systematically examining these implementation issues is essential in order understand how best to disseminate CPP to new settings.

RESEARCH AND PRACTICE

By encouraging such explicit operationalization of implementation, research may help provide some clarity for infant mental health practices. The challenge for practitioners is developing articulated models that outline how infant mental health approaches are brought into services, what support is available for these approaches, the impact such support has on the way services are delivered, and what difference this makes with children and families. At the same time, the challenge for infant mental health researchers lies in finding ways to examine these models while honoring the complexity of this work. Research, both qualitative and quantitative, is inherently reductionistic, where coding and classification are part of the process. But in listening to therapists presenting case studies of families with whom they have worked, I am always struck by the need to be flexible in the moment with families, and open to the many routes that they may take to find their way home.

One of the primary benefits of participating in the PDN has been my involvement in rich, cross-disciplinary discussions with other PDN members that have articulated this tension between research and practice. We have discussed the limits of randomized trials as well as the knowledge that can be gained from them. We have explored idiosyncratic family histories and wondered how they can be applied beyond that one family. We have considered adaptations and innovations to practice that have to be made in order to accommodate different cultures and communities, which is both a central tenant of diversity-informed practice (St. John, Thomas, & Noroña, with the Irving Harris Foundation Professional Development Network Tenets Working Group, this issue, p. 13) and an important (and understudied) strategy in dissemination of evidence-based practice (Durlak and DuPre, 2008).

Ultimately, infant mental health research and practice have a common goal: to build a coherent and accurate story of the healthy social and emotional development of infants, toddlers, and their families--whether this development occurs in a context of adversity or in a fortunate environment that is free enough from stress and trauma—and to discover the most effective ways to support this development.

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His research examines the implementation and outcome of early childhood interventions, as well as policies and practices in early childhood mental health, with an emphasis on workforce training and development. He is also directing a training program in Illinois for mental health therapists interested in using Child-Parent Psychotherapy with families of young children exposed to trauma. He is a graduate fellow of the national organization ZERO TO THREE.

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Creation of a Developmentally Sensitive Measure of Parenting Self-Efficacy

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The authors of this article represent three generations of infant mental health (IMH) professionals. Their training, research, and clinical experiences in IMH reflect the growth in the field over the past 30 years and the role of ZERO TO THREE, the Irving Harris Foundation, and the Harris Professional Development Network (PDN) in shaping their professional development by providing a framework for developmentally and relationally oriented clinical and research endeavors. The third author, Dr. Troutman, began graduate training in clinical psychology at the University of Iowa, researching difficult infant temperament, parenting self-efficacy (PSE), and postpartum depression. She was introduced to the concept of IMH by the book *Infants and Parents*, edited by Dr. Sally Provence, which led her to an internship in clinical child psychology at the Yale Child Study Center (a PDN site). Drs. Moran and Franklin completed clinical practica in IMH with Dr. Troutman who was then on the clinical faculty in psychiatry at the University of Iowa. Dr. Moran pursued pre- and post-doctoral training at Tulane University, another PDN site. She now teaches within the Irving Harris IMH program at Erikson Institute, also a PDN site, and is the doctoral advisor of Ms. Evenson. Through three generations of professionals, the training opportunities and mentoring in IMH supported by the Irving Harris Foundation have infused IMH principles into our work and the work of the generations to follow. The PDN continues to be influential in our work, both clinically and with regard to our research. That influence can be seen in the principles that guided the development of the Assessment of Parenting Tool (APT), the subject of this article.

DEFINITION OF PSE

The APT is a measure of PSE, a concept dating back to the work of Bandura during the 1970s. Consistent with IMH principles, PSE refers to parents' beliefs regarding their capabilities to perform the numerous

and changing tasks associated with parenting a particular infant (Coleman & Karraker, 1997). Knowledge about child-rearing behaviors and confidence in one's ability to perform these behaviors are both aspects of PSE.

Relationship-specific differences in PSE may be useful as indicators of areas of strength or weakness for a parent. For example, if a mother rates herself as efficacious in parenting her toddler but not her newborn, an IMH professional might use this to guide her approach by reinforcing the mother's competence with her toddler while supporting the mother's PSE with her newborn. Specific assistance could vary widely from offering concrete suggestions about breastfeeding or bathing a newborn to exploring concerns about balancing the emotional needs of a newborn and a toddler or adjusting to the new baby's temperament.

Perceived self-efficacy is found across numerous studies to be related to psychosocial variables and mental health for both the parent and infant. When low self-efficacy exists in a domain of great personal importance, such as parenting, distress is a likely result (Bandura, 1989). Low PSE is associated with parental anxiety, depression, stress, negative cognitions, learned helplessness, passive coping style, coercive discipline, and demoralization (Bandura, 1992; Coleman & Karraker, 1997; Cutrona & Troutman, 1986; Donovan, Leavitt, & Walsh, 1990; Goodman, Brogan, Lynch, & Fielding, 1993; Ozer & Bandura, 1990; Wells-Parker, Miller, & Topping, 1990).

DEVELOPMENT OF A PSE MEASURE

This article describes the initial validation study of the APT. Within their research and clinical work, the authors became aware of the limitations of currently available measures of PSE. Specifically, the measures included few items, cut across broad age ranges, were subjected to minimal validation, and were created using nonrepresentative samples. The APT is designed to address these problems by measuring PSE in a comprehensive, culturally and developmentally sensitive manner during the first 2 years of life. In so doing, the APT is being developed in a manner informed by and consistent with the PDN's Diversity-Informed Infant Mental Health Tenets (St. John, Thomas, & Noroña, with the Irving Harris Foundation Professional Development Network Tenets Working Group, this issue, p. 13). The APT is designed to have utility in treatment outcome studies, in prevention programs, and in enhancing the theoretical understanding of PSE and its relationships to other important psychosocial constructs.

HOW TO CREATE A STRONG ASSESSMENT TOOL

Developing a new assessment tool involves a systematic process designed to answer the question, "Does the created scale actually measure what it is intended to measure?" After identifying the limitations of previous measures, the authors discussed their conceptualizations of PSE and how they would know a parent had high or low PSE (i.e., content validity). Next, they discussed what variables PSE should be associated with and how PSE was distinct from other similar concepts (i.e., what other concepts are related to PSE [construct validity], but distinct from PSE [discriminant validity]). The specific items included in the APT were written and reviewed by the authors. The APT was then administered to a small group of parents as a pilot prior to being administered online to a much larger group of parents.

Validation studies provide information on the measure's reliability and validity. With sufficiently large samples, data from item-level analyses can be used to identify strong and weak items. This data can be used to guide changes to the measure and create a stronger assessment. Several established measures of constructs known to be related to PSE (e.g., depression, anxiety, social support) and previously established measures of PSE are administered along with the new measure in order to evaluate construct validity (Campbell, 1959). Whether a measure has adequate construct validity is therefore judged on the basis of the correlations with other related and established measures in the initial validation studies. The statistical analyses used to assess the measure's reliability and validity necessitate numerous participants to develop a strong assessment.

VALIDATING THE APT

Online recruitment was used to recruit a large sample to validate the APT. Online measurement is an efficient means of acquiring psychological data as it provides greater convenience and anonymity than traditional paper-and-pencil methods. Via online recruitment, we were able to recruit a large pool of participants ($N = 1{,}376$) who were self-identified parents (mothers, $n = 1{,}231$ and fathers, $n = 44$) of infants ages birth to 24 months old. The majority of participants were married (82%). Around half of the participants did not have other children living at home (52%). Participants were predominantly Caucasian. However, African Americans, Hispanic/Latina, Asian, Native American, and other races were also represented. Participants tended to be well-educated, with a majority completing some college education or higher. A range of estimated total household incomes were represented. This convenience sample of online respondents does not adequately represent the diversity of parents that we plan to reach in future validation studies of the APT.

In addition to completing the APT, parents completed other measures of PSE (the Maternal Efficacy Questionnaire; Teti & Gelfand, 1991) and the revised Parenting Self-efficacy subscale of the Parenting Sense of Competence Scale (Gibaud – Wallston & Wandersman, 1978; Johnston & Mash, 1989), as well as measures of constructs related to PSE (Edinburgh Postnatal Depression Scale; Cox, Holden, & Sagovsky, 1987), The Postpartum Worry Scale-Revised (Wenzel, Haugen, Jackson, & Robinson, 2003) and The Interpersonal Support Evaluation List–12 item (Cohen & Hoberman, 1983).

There are currently six versions of the APT which are based on infant's age at the time of the test (i.e., birth to 2 months, 3 to 5 months, 6 to 9 months, 10 to 12 months, 13 to 18 months, and 19 to 24 months). Item content is based on developmental charts; prior measures of PSE; and expert opinions from PDN colleagues, PSE experts, and child development faculty at Erikson Institute. A 5-point Likert scale ranging from *not at all confident* at 1 to *very confident* at 5 was used. On each age-specific version of the measure, between 30 and 37 developmentally appropriate task level items addressing both knowledge and skills (e.g., "care for my infant's umbilical cord" on the birth to 2-month version and "support my toddler in walking and/or running" on the 19–24-month version) are included. Twelve domain levels items which cut across developmental stages are also included on each version of the measure (e.g., "I cope well with becoming a parent or having another child," "I would be a good person for another parent to learn from").

UTILITY OF THE APT

Overall, our results (available upon request) provided support for the construct validity of the APT (i.e., correlations were consistent with expectations derived from the PSE and self-efficacy literature although results were not as strong for parents of newborns). These findings could result from the special challenges associated with parenting a newborn or a methodological issue such as the smaller number of participants in the newborn group.

The brevity and ease of administration of the APT makes it possible to use for periodic screening in a variety of settings. As we know from prior research that PSE tends to increase over time among mothers both of typical and of challenging infants and is correlated with depression and anxiety symptoms, declines in PSE may be a good indicator of the mother's need for additional consultation and support. The APT is designed to facilitate a conversation between an IMH professional and the parent around specific tasks the parent finds challenging, or about the parent's adjustment to current parenting demands, or both. The specific tasks a parent indicates they struggle with may or may not be what the provider expects on the basis of their observations and experiences with the dyad.

Consistent with our goal of developing a culturally sensitive and broadly applicable measure of PSE, targeted recruitment of more diverse groups is warranted in future validation studies of the APT. The vast majority of our participants were mothers. In future studies we plan to specifically target fathers to enhance our understanding of their PSE development. We have begun to target Hispanic/Latina parents via recruitment at a West Chicago neighborhood health and wellness clinic that provides clinical services to Latino parents. Using collaborations of this type, the APT validation process can assist in parent–child relationship screening and assessment across racial and socioeconomic groups. In part because of our desire to validate the APT for use with multiple groups, it is difficult to predict when the APT will be ready for dissemination and clinical use. However, research is ongoing, and our goal is to publish the APT in a validated, ready-for-use format within 2 years from this publication's date.

APPLICABILITY TO WORK WITH PARENTS

Effective approaches to intervening emphasize the parent's ability to address problems through their own skills and efforts. Strategies to promote PSE include emotional support for parenting struggles, mutual creation of achievable goals, and noting the positive effect their efforts have on their child. For example, parents who indicate soothing their infant is an area in which they want assistance, rather than directly demonstrating soothing techniques on the fussy baby, the PSE sensitive approach would allow the parents to take the lead, demonstrating what they have tried in the past and remarking on where they want assistance. Providers may promote PSE by assisting parents to feel as though they can bring about the change they are seeking in their infants and themselves. Alternatively, ineffective interventions attempt to solve the problem for the individual, provide the individual with strategies they are unable or too overwhelmed to implement, provide recommendations on topics the parent is not seeking assistance with, or provide the parent with strategies that are ineffective for their family. The considerations in providing PSE promoting treatment are akin to the proverb concerning giving a man a fish. "A clinician who calms a fussy baby, calms them for an afternoon; a clinician who supports the parent to feel more efficacious in calming their baby, supports the relationship for a lifetime." We hope the APT will assist providers in understanding and supporting parents' self-efficacy.

Tracy E. Moran, *PhD, is an assistant professor in Infant Studies at Erikson Institute, a graduate school in child development. She teaches courses in parent–child relationships as well as in child and relationship assessment. Her research interests include promotion and assessment of parenting self-efficacy, intervention and assessment of postpartum mood and anxiety difficulties, and effective means of treatment provision for parent–child relationship issues within diverse cultural contexts.*

Christina Franklin, *PhD, is a pediatric neuropsychologist at the Alexander Center. She provides clinical services to families where there are concerns regarding emotional development, developmental disorders, autism, trauma, and fetal alcohol syndrome. She trains psychology students in infant mental health and therapeutic assessment. Her research projects include: the emotional regulatory development in infants of postpartum depressed mothers, parental readiness to implement recommendations from evaluations, and parent support group efficacy for children with autism spectrum disorders.*

Beth Troutman, *PhD, ABPP, is clinical associate professor of psychiatry at the University of Iowa Carver College of Medicine. She provides clinical services to parent–child dyads in which there are concerns about attachment or disruptive behavior and has a special interest in clinical services for families involved in the child welfare system. She trains community providers, psychology students, and psychiatry residents in infant mental health, attachment theory, and Parent-Child Interaction Therapy. Her research projects include: the impact of infant temperament on parenting self-efficacy and depression, postpartum depression in adolescent mothers, the impact of temperament and nonparental child care on attachment, attachment in adults who were adopted as infants, in-utero exposure to anti-depressants and infant–mother attachment, and prescription of psychotropic medications to young children in foster care.*

Amber Evenson, *MS, EdS, is currently a second year child development PhD student at the Erikson Institute. She practiced as a school psychologist for 4 years after receiving her master's and education specialist degrees from the University of Wisconsin–Milwaukee. Her research interests include infant-parent relationships, parenting self-efficacy, familial sleeping approaches, and the role of culture as it pertains to these topics.*

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The Neural and Psychological Dynamics of Adults' Transition to Parenthood

Linda Mayes, Helena Rutherford, Nancy Suchman, and **Nancy Close,** Yale Child Study Center

For decades, clinicians and developmental scholars have focused on how individual differences in parental care impact infant and child development. This accumulated work has shown that early relationships and parental care play a critical role on a child's developing brain architecture, social and cognitive development, and life-long health outcomes (Center on the Developing Child at Harvard University, 2010; National Scientific Council on the Developing Child, 2007; Shonkoff, Boyce, & McEwen, 2009;). Within the parent–child dyad however, the adult as a parent is also developing. The parents' development is a reflection of their own early experiences as well as their neurobiology, and parental development at all levels of analysis is facilitated by the act of caring for another—the adult side of the "serve and return" interactions so critical for infant and child development. How adults transition into parenthood has become a key question and area of focus for many developmentalists. Specifically, what are the neural and psychological changes that occur (and must occur) as both women and men assume the care of their infant? What are the sources of individual variation in that psychological and neuropsychological transition? How can prevention and intervention efforts impact that adult transition before or in the presence of a new infant when needed?

Converging studies from the clinical and preclinical worlds are shedding light on how there are significant neurobiological and neurophysiological changes subserving the transition to parenthood. These include a host of structural and neurochemical changes indicating plasticity at the neural regions, synaptic, and transcriptional regulation levels of control (Rutherford, Williams, Moy, Mayes, & Johns, 2011; Rutherford, Potenza, & Mayes, 2012a) suggesting the dynamic nature of neural systems in adulthood, especially under the influence of attachment related experiences. Central to the transition to parenthood (although mothers are, to date, more often studied than fathers) are significant changes in the function of key brain regions involved in reward and motivation, as well as stress and emotion regulation and the production of the oxytocin (OT), a neuropeptide involved in the regulation of uterine contractions, milk release, and affiliative behavior. For example, Strathearn and colleagues (Strathearn, Fonagy, Amico, & Montague, 2009) have shown that mothers recruited regions of the brain that are regulated by dopamine (a neurotransmitter key to reward and motivation regulation) when viewing photographs of their own smiling infants but did not do so when viewing unfamiliar infants. Further, individual differences in maternal attachment (based on mother's own parenting) predicted divergence in regions of brain activity in response to viewing infant faces. Specifically, securely attached mothers show heightened activity in reward regions while insecurely attached mothers show a stronger response in the right insula, an area associated with anticipated loss. Further, changes in peripheral levels of OT following mother–child play correlated with brain activation in hypothalamic–pituitary regions when mothers view photographs of their own infant compared to an unknown infant, and this OT response was stronger in securely attached mothers compared to insecurely attached mothers. Findings such as these are being replicated in ours and others' laboratories in which it also appears that with increasing exposure to the infant, there is consolidation of specific neural circuits around response to salient infant cues.

Additional lines of work highlighting the neurophysiological changes accompanying parenting point to heightened perceptual sensitivity to infant cues (auditory or visual) as measured by electrophysiological studies as well as alterations in neurophysiological markers of emotion regulation in mothers compared to non-mothers (Rutherford et al., in press). Finally, preclinical models of parenting suggest that early parenting experiences set response thresholds in key neural and perhaps genetic transcriptional systems such that individual differences in parenting are transmitted intergenerationally (Rutherford et al., 2011). How this apparent neural and physiological reorganization and adaptation is impacted by a host of adversities including depression, addiction, and anxiety in adults who are parents is also a topic of ongoing study in our research group using both functional brain imaging and neurophysiology methods while mothers respond to infant faces and infant cries.

How does this emerging literature on the social neuroscience of parenting influence prevention and intervention programs with parents and their infants? For one, thinking of adult brain and psychological development as occurring simultaneously with infant brain and mind development focuses as much on helping adults understand the changes in their own psychology as those of their infant. It requires clinicians and investigators to think about parenting interventions as more than providing education on what the infant needs. It is important to understand how parents' own feelings and expectations of their role impacts their behavior and understanding of their infant—and how their infant impacts them as much as what their infant needs from them. These kinds of parenting

intervention efforts may be broadly described as parental reflectiveness or mindfulness approaches. The goal is first to engage parents in thinking about and reflecting on their own development as a parent. The approach also engages parents in learning and enhancing skills from reflectiveness to a range of executive control capacities (e.g., planning, attentional focus, distress tolerance) in the service of their parenting role.

Minding the Baby is one such program that, through intensive home-based work with first-time parents and their infants, focuses on how adults develop an awareness of their own needs and skills as a parent just as they learn about their infant and their relationship (Sadler, Slade, & Mayes, 2006; Slade, Sadler, & Mayes, 2005). The core aims of the program are to promote positive physical and mental health, life course, and attachment outcomes in high-risk babies, mothers, and their families living in urban poverty. Distinct features of the program include

1. Intensive services are provided by an interdisciplinary team that includes a licensed clinical social worker and a pediatric nurse practitioner,
2. The enhancement of parental reflective functioning is an essential focus of both the infant mental health and health aspects of the intervention, and
3. The program is embedded within well-established community health centers in the inner city.

A second model, Mothering from the Inside Out, applies similar ideas to center-based services for substance-using mothers struggling to manage or overcome their addiction as they also try to parent their children (Suchman, DeCoste, McMahon, Rounsaville, & Mayes, 2011). Offered in conjunction with outpatient substance abuse treatment, mothers participate in weekly individual therapy focusing on problem solving and coping emotionally with the everyday stresses of being a mother. A developmentally trained child care team supports the growing communication capacities of the young children. As a whole, the clinic functions as a milieu that supports the dyad's regulatory functions by simultaneously supporting mother's reflective and the child's communicative capacities.

The results of focusing more directly on parental development in either model reveal promising changes in parents' behavior toward their children, in their approach to their own self-care and management of their own needs, and their overall ability to think about their own and their infants' feelings, desires, and ways of understanding the world. These programs also represent an example of how clinical science and clinical interventions inform one another inasmuch as much of our basic research focuses on how mothers think about and respond to infant cues at both a behavioral and neural level, the same area of focus for these two intervention efforts. Further, in both the clinical research and clinical interventions, we are focusing on how adults transition to parenthood and how the individual differences in that transition impact both maternal and child health.

Translating these efforts to understand the development of the parental brain and mind into effective prevention and intervention programs for parents and their families also expands the mandate of effective policies for services for young children by calling attention to a very open, dynamic adult developmental phase initiated by the demands of caring for an infant. When seen in this light, it is clear that services for young children must include services facilitating adults' development and capacity building for their roles as parents. A multilevel approach that bundles services for adults with services for infants and families stands to impact not only the infant's health and development but also the next generation.

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Helena Rutherford, *PhD, is associate research scientist, Yale Child Study Center. Dr. Rutherford's research focuses on understanding how brain and behavior change when adults become parents. She uses neuroscience and behavioral experiments to explore how mothers respond to infant signals of emotion (e.g., crying) and how mothers regulate their emotional response to those infant signals.*

Nancy Suchman, *PhD, is associate professor in the Yale University School of Medicine Department of Psychiatry and the Yale Child Study Center. She is also associate director of research on substance abuse and the family and a practicing licensed clinical psychologist with extensive experience providing and supervising psychotherapy in the PIO programs at Yale. Her research interests include attachment-based intervention development for parents with substance abuse and psychiatric problems, and she has extensive expertise in substance abuse, personality disorders, adult psychotherapy development and evaluation, and qualitative methods.*

Nancy Close, *PhD, is assistant clinical professor, Yale Child Study Center. Dr. Close specializes in the assessment and treatment of children less than 5 years old. She teaches Yale College students and fellows in training at the Child Study Center. She conducts developmental assessments of young children and does dynamically oriented psychotherapy with children. In addition she provides mental health consultation to early childhood education programs in the community.*

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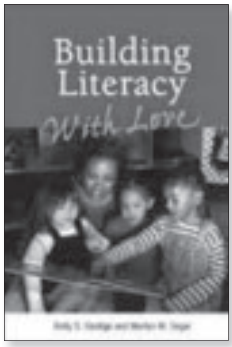

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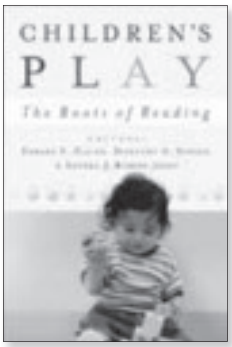

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Jargon Buster

Given the multidisciplinary nature of our work with infants, toddlers, and families, we often come across words or acronyms that are new or unfamiliar to us. To enhance your reading experience of this issue of *Zero to Three,* we offer a glossary of selected technical words or terms used by the contributing authors in this issue. Please note that these definitions specifically address how these terms are used by the authors in their articles and are not intended to be formal or authoritative definitions.

Phrase	*What it means*
Diversity-Informed Infant Mental Health Tenets	The Diversity-Informed Infant Mental Health Tenets have been devised to support infant mental health professionals in the goal of striving for the highest possible standard of inclusivity in all spheres of practice: teaching and training, research and writing, policy and advocacy, as well as direct service. [Find it in St. John, Thomas, & Noroña, with the Irving Harris Foundation Professional Development Network Tenets Working Group, page 13]
The FAN Approach	FAN is a conceptual model and practical tool for family engagement. Developed by the Erikson Institute Fussy Baby Network®, it is an approach to engaging parents around their urgent concerns about their baby's crying, sleeping, or feeding in a way which builds their longer-term capacities as parents. [Find it in Gilkerson et al., page 59]
The Irving Harris Foundation Professional Development Network	The Irving Harris Foundation Professional Development Network is a network of 18 grantees that represent leaders and innovators across disciplines with the potential to have great influence on the infant mental health field. Funded by the Irving Harris Foundation, the Professional Development Network evolved out of Irving Harris's appreciation for the importance of supporting very young children's mental health and development and his recognition that there was a critical need to strengthen the infrastructure of the field through multidisciplinary training and leadership development. [Find it in Glink, page 5]
Implementation Science	Implementation science is the study of the effectiveness of an intervention to gain a clearer understanding of the components of effective interventions and involves, for example, examination of the programs themselves, what goes into the programs, and what happens when a family actually engages in these services. [Find it in Korfmacher, page 78]
Learning Collaboratives and Learning Communities	A learning collaborative is a model of training with very specific features: (a) multiple teams work together to learn or improve a practice or a system, learning from their collective experiences and challenges; (b) the training extends over time giving the teams time to adopt effective practices that facilitate the implementation of the practice in their settings; (c) a structured learning process that includes sustained learning and opportunities to practice new skills and share progress with other teams; (d) a learning process that includes techniques that lead to accelerated improvement, including small tests of change and the collection of team metrics as an integral part of the training; (e) a learning process that involves participation by members at various levels of the organizational hierarchy on the team, providing for give-and-take on both the clinical and the administrative practices required for implementation of a practice (Markiewicz, Ebert, Ling, Amaya-Jackson, & Kisiel, 2006). Learning communities are similar to learning collaboratives in that they extend over time, but they may not have all of the features described above. For example, individuals rather than teams may come for training, or metrics may not be an intrinsic part of the training process. [Find it in Van Horn et al., page 48]

Markiewicz, J., Ebert, L., Ling, D., Amaya-Jackson, L., & Kisiel, C. (2006). *Learning collaborative toolkit*. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

UPCOMING ISSUES

January: New Research on Home Visiting
March: Infants, Toddlers, and Technology
May: Early Childhood Mental Health Consultation

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