ORGANIZATIONAL ENVIRONMENTS THAT SUPPORT MENTAL HEALTH

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This essay is a synthesis drawn from presentations made by the authors at the October 2000 Infant Mental Health Forum.

Early Head Start and other community-based programs can offer infants, toddlers and their families a network of consistent, nurturing relationships. Such relationships can foster very young children's healthy social and emotional development by influencing the child directly, since everything that children learn about themselves as individuals and the way they make sense of their experiences are deeply rooted in the nature of their relationships with others. Strong early childhood programs can also influence other relationships – especially the relationship between child and parent. Program staff in many roles have unique opportunities to promote mental health, and to recognize and address mental health problems.

In order to realize their potential to contribute meaningfully and to the mental health of infants, toddlers, and families, the staff of community-based programs need to:

- Develop strong working relationships with parents;
- Pay attention to the physical *and* emotional quality of the environment;
- Work intentionally to support very young children's emotional regulation and emerging prosocial behavior;
- Recognize what they bring – in their professional roles and from their personal experience – to their work with infants, toddlers and families; and
- Give and get the kind and level of support that such intellectually and emotionally demanding work requires.

Three beliefs characterize an organizational culture that facilitates infant mental health:

1. Learning is a lifelong process.
2. Learning is reciprocal — everyone in an organization learns and develops together.
3. Relationships build over time, relying on accumulating trust and emotionally sensitive communications.

"Reflective practice" is a term that many people use to describe what programs do to actively embrace these beliefs – to establish and maintain an organizational culture that facilitates mental health.

Reflective practice can be described as the art of "stepping back" to examine what one is observing or doing (thus it requires a certain level of comfort with self-examination). It is a skill that takes time and ongoing support to develop and practice consistently. *Reflective supervision*, the availability of a *trained infant mental health specialist*, and appropriate *continuing education* are program elements that support reflective practice.

- ***Reflective supervision*** is an opportunity to reflect with another in order to grow professionally. In addition to *reflection*, supervision that supports reflective practice includes *collaboration* between supervisor and supervisee, so that power is mutually shared, and *regularity*, so that supervision become a predictable "oasis" of calm and thoughtfulness, free from intrusion or distractions, amidst the demands of daily work (Fenichel, 1992; Gilkerson & Shahmoon-Shanok, 2000). Reflective supervision encourages participants to see alternatives, plan activities, extend empathy, and build their capacity to support emotional regulation. Guided reflection also helps practitioners to make use of their experiences appropriately, while minimizing the influence of unexamined attitudes or "ghosts" from the conflicted past (Fraiberg, Adelson & Shapiro, 1975). In the process of repeated trial and error that all infant/family work

entails, reflective supervision – group or individual — allows practitioners to build competence as they share dilemmas safely with colleagues, preserving confidentiality and respecting other boundaries.

- ***A trained infant mental health specialist*** on-site in an Early Head Start program, child care center, or other community-based program is important for daily work and consultation with staff, as well as with families and children. In addition to conducting or overseeing reflective supervision an infant mental health specialist may:
  - engage in parental guidance and developmental counseling related to infant mental health;
  - screen and/or assess children for developmental delays, disabilities, and mental health problems and make referrals as necessary;
  - respond to emotion-based crises in children and families, and be available for short-term interventions;
  - support and mentor staff around mental health issues;
  - consult on matters of child protection and reporting of suspected abuse or neglect;
  - help staff understand the importance of relationships and relationship building, as well as the impact of disruptions in relationships;
  - observe, listen, and to some extent become immersed in program activities; and
  - on occasion, provide relationship-focused therapy with child and parent (Ervolina, personal communication).
- ***Continuing education*** to improve the mental health knowledge and skill of all staff of community-based infant/family programs should match local circumstances, local needs, and local opportunities. There must be cultural sensitivity, competence, and responsiveness to the traditions of the populations being served. Any "top-down" approaches to teaching infant mental health (for example, a "train the trainers" initiative at a national center) needs to be balanced with expert training on-site and in community-based contexts. If an infant mental health specialist is charged with much of the responsibility for continuing education of staff, the specialist must be prepared to address local problems and opportunities. For example, in one community, a number of young children and parents may be suffering from traumatic or post-traumatic stress disorder, and there may be an opportunity to join in a community-wide violence prevention initiative. At another site, parental depression, substance abuse, and family disorganization may be the focus of attention. Staff of one program may be most interested in learning how to structure the environment to facilitate self-regulation among infants and toddlers who are experiencing difficulty in this domain; at another site, the infant mental health specialist may be asked to train home visitors in interaction guidance (see Solchany & Barnard, this issue).

Two Models of Supervision That Supports Reflective Practice

In Italy, the community-based early childhood education approaches known as Reggio Emilia and those of related infant-toddler centers (Edwards, Gandini & Foreman, 1998; Gandini & Edwards, 2001) create environments in which parents, staff at all levels, and children are involved together in continuous learning and reflection. Learning is viewed as relationship based; each child is immersed in a network of carefully cultivated, emotionally warm and responsive relationships. Experiences of conflict and difference are valued as opportunities for discussion, repair of relationships, and reaching new points of view. All of this takes time: Teachers and other staff spend a major part of their time each week collaborating with others in mutual supervision and in critical discussions that are based on their experiences and observations. Thus supervision and monitoring are built into program culture, as helpful and important ways of putting into practice the belief that children, parents and staff are all learning and developing together.

The traditions of clinical mental health practice offer a second model of consultation, coaching, and reflective supervision. Clinical psychologists, psychiatrists, and social workers think of supervision as an individually tailored opportunity to learn. Supervision is a highly valued component of training and the early years of practice; even experienced mental health clinicians continue to seek supervision and consultation from colleagues. In mental health settings, a continuous atmosphere of mutual consultation and learning may begin with regularly scheduled opportunities for reflective supervision, but it also contains daily opportunities for mutual consultation among professionals as they confront the uncertainties and difficulties of mental health practice. This model recognizes that working with people who have mental health problems – adults or children – is likely to arouse discomfort and stir up one's own problems. The helper often needs the opportunity to gain perspective and support from others. An organizational environment that values communication and support among professionals, where all are learning together, can overcome the feelings of bewilderment, disorganization, and helplessness that often accompany work with suffering young children and families.

at a glance

- "Reflective practice" describes what programs do to establish and maintain an organizational culture that facilitates mental health.
- Reflective supervision, the availability of a trained mental health specialist, and appropriate continuing education are program elements that support reflective practice.
- An organizational environment in which all staff are learning together can overcome the painful feelings that often accompany work with suffering young children and families.

Reflective Environments in Early Head Start

At the Ounce of Prevention's Early Head Start program, which offers comprehensive home and center-based support, care and education for first-time pregnant teen parents, staff have distilled ten lessons from work over the course of the past six years. These lessons continue to provide a focus for training, practice, reflection, and planning for the future.

1. **Working toward the integration of Early Head Start and Head Start** (and other early childhood programs) recognizes the continuous development of young children's social and emotional competencies in the first five years of life. Well-planned transitions for children and training shared among early childhood programs are strategies for achieving this goal.
2. **A clear focus on development** – of both child and family — at formal staffings and team meetings leads to meaningful prevention and intervention planning. The developmental focus becomes the program's "north star."
3. **Training in observation** enables staff of home-based and center-based programs to capture meaning from interactions between parent and child, staff member and child, staff and family, and between children. Meaningful interactions are the basis for relationships; understanding them is thus essential to relationship-based practice.
4. **Intensified training on relationship building and interdisciplinary work** is important as community-based programs strive to become more comprehensive. Moving beyond discipline-specific traditions of communication, planning, and evaluation to a new, integrated vision takes time.
5. **The younger the child, the more critical it is to understand the family – the child's environment – in order to support healthy social and emotional development.** Family support staff in Early Head Start and other 0-3 programs should have the training and organizational support they need to understand participating families, in the context of culture and community, and communicate their understanding to other program staff. Such a change in EHS and birth-to-three programs will influence Head Start and other programs for preschoolers.
6. **Family support workers' case loads must be reduced** in order to build "deep" programs that can help families make changes in their lives, achieve goals and realize their dreams for their children.
7. **Infant mental health consultants should work with programs on a regular basis.** Children's social and emotional development needs ongoing regular attention. However, expert consultation is expensive, and in many communities may be difficult or impossible to find at any price. Increased financial support at the national level is needed to train infant mental health consultants and pay for their services.
8. **The basic qualifications – and job descriptions — for staff working with infants and toddlers in all capacities in programs that serve families with very young children deserve re-examination** as our learning and expectations for very young children evolve. Program staff should ask themselves the same questions they ask parents: What are our hopes and dreams for the babies and toddlers that we serve? Then, what do we need in order to achieve our goals— and be accountable for child outcomes? Clearly delineated roles and areas of responsibility for staff supported by reflective supervision, are an important part of the answer.
9. **Programs serving infants, toddlers and their families are poised for a major shift.** Providing a nurturing, supportive, and restorative environment, rich with a range of experiences for all involved, requires a shift from a traditional classroom model to a comprehensive program that embraces families and their children. Expect resistance – it means that change is underway!
10. **Families and their children, from before birth to five years, need a seamless service delivery system.** Achieving this vision demands that community-based programs review and change their infrastructure, seek out and blend funding from both public and private sources.

Conclusions

If we really believe that everything children learn about themselves as individuals, and how they make sense of their experiences, are deeply *rooted* in the nature of their relationships with others, then programs designed to serve families with young children should reflect this belief in all that we do. This means creating – and sustaining — an organizational infrastructure sturdy enough to support reflective practice and reciprocal learning. To nurture our youngest children in networks of trustworthy, emotionally warm relationships, we must commit our resources – in community programs, and as a nation – to this goal.

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