PATHWAYS TO PREVENTION: A comprehensive guide for supporting infant and toddler mental health

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No matter how mental health services are delivered, the understanding of mental health is the same: prevention first, promotion always, and intervention when necessary.

(White-Tennant & Costa, 2002, p. 6)

Early Head Start (EHS) programs and their early care and education partners are in a key position to support the mental health of infants and toddlers as well as their parents. A warm and welcoming voice on the phone can reassure an anxious parent that someone cares. A trusted infant-toddler teacher can support a mother to consider an evaluation for a toddler with a speech delay. A home visitor who has known an energetic 2-and-half-year-old and her parents since the baby's birth can help the family transition from home to child care with a clear sense of what to expect from their little girl and how to respond to her fears and excitement.

Infants and toddlers develop a sense of who they are and what they can expect in the context of their daily interactions with parents and other significant people. Although infants come into the world ready to communicate, they rely on caregivers to help them organize their emotions and focus their attention. Through interacting with parents and teachers and by observing parents and teachers interacting with one another, an infant achieves a more or less positive sense of emotional and social well-being and begins to explore and learn about the world. Relationships shape how an infant will express the unique blend of characteristics he or she brings into the world.

However, infants are not passive players. Research now confirms what parents and other primary caregivers such as grandparents have "known" for generations: Infants and toddlers contribute to the parenting relationship, influencing interactions and the parents' sense of competence. A robust, outgoing baby who has a relatively easy time receiving comfort and establishing routines will have a different effect on his or her parents than a frail baby who has a difficult time receiving nourishment or physical comfort. Over time, parents develop skills and learn what works well for them and their young children. And in the process, parents develop questions and concerns. When parents have social and emotional support, they more easily nurture their infants and toddlers as well as ask for help.

In a parallel process, staff members who work with parents and their young children rely on the nurturing connections that they develop with others to do their work well and expand their skills. Supervisory relationships within programs can help staff members to identify their knowledge, skills, and next steps in development and can enable these staff members to then support the rapid social and emotional development of infants and toddlers as well as parents. Naming what works well with individuals, families, and programs and then building on those approaches provides a foundation for supporting infant and toddler mental health.

This publication will provide guidance to program leaders and staff members for planning, carrying out, and assessing their infant-toddler mental health services. Programs differ in how they structure services. For example, some programs contract with outside consultants who are experts in infant mental health, and other programs integrate the mental health services within their programs. Nonetheless, all programs rely on relationships among leaders, staff members, parents, and infants and toddlers to promote infant-toddler and family mental health and to intervene when concerns arise.

This publication is designed for programs with different structures and leadership styles. It integrates practical considerations for carrying out a comprehensive approach to infant-toddler mental health and for accessing community resources. This resource can be used to assess current program effectiveness, plan next steps, and evaluate the outcomes.

The first section of the document, "A Framework for Infant-Toddler Mental Health," reviews the history of the mental health initiative of the Head Start Bureau and describes the pivotal role that relationships have for achieving social and emotional well-being. The section also discusses the painful reality that some infants and toddlers may suffer from emotional disorders, and it describes elements of resilience that can buffer and support parents and young children.

The second section of this publication, "Integrating Principles of Mental Health into Your Program," highlights six building blocks that support successful program approaches to infant and toddler mental health. This section identifies successful strategies in core program areas: curriculum and individualization, environments, screening and assessment, partnerships with

community mental health providers, management systems, and human resources. In addition, it identifies potential challenges that might create obstacles to fully integrating mental health services provided in home-based or center-based settings in rural and urban areas, and it suggests ways to meet those challenges. The section concludes with an example from the field that illustrates how one program influenced the mental health of a toddler.

The final section of the paper, "Additional Resources", suggests written materials and Web sites that programs can use to support their work, and it highlights local and national initiatives and associations that address infant mental health.

A FRAMEWORK FOR INFANT-TODDLER MENTAL HEALTH

Early Head Start began in 1995. The impetus for its development was the recognition that what occurs during pregnancy and the first 3 years of life is critical to healthy development. Building on the successes of Head Start and its comprehensive approach to child development and education services, EHS specifically approached mental health as being an integral part of the process to support children and families.

As EHS programs have evolved, a combination of directors, managers, home visitors, teachers, and parents voiced concerns about how to define and address the mental health needs of infants and toddlers and their families (Head Start Bureau, 2000). Staff members and parents wondered how to promote positive social and emotional development; how to identify infant, toddler, and caregiver mental health problems; and how to intervene while retaining a focus on the strengths of each young child and each family. Questions emerged about how to understand and define infant mental health and how to find partners in the larger social service and medical community who were skilled in understanding such a

young population and who could provide support and guidance to programs and the infants, toddlers, and families they serve.

In response to concerns, the Administration on Children Youth and Families, under the leadership of the Head Start Bureau and the Commissioner's Office of Research and Evaluation, held an Infant Mental Health Forum on October 23–24, 2000. The forum brought together more than 140 people representing parents; EHS and Migrant Head Start directors, program staff members, and home visitors; early educators; training and technical assistance providers; researchers; pediatricians; psychiatrists; psychologists; occupational therapists; social workers; federal partners; and private foundation representatives. Since the forum, the Head Start Bureau and the Early Head Start National Resource Center, in collaboration with the Child Care Bureau and leaders in the field of infant mental health, have continued to meet to support the work.

Beyond the forum, the recent synthesis of 35 years of early childhood research (Shonkoff & Phillips, 2000) confirms the critical link between infants' and toddlers' emotions and learning. Infants clearly come into the world focused on communicating and relating to others. Daily interactions observed in programs emphasize the link between responsive relationships and the physical, cognitive, and emotional development of infants and toddlers. However, the staff of early childhood programs describe the reality that adults who struggle with their own mental health issues such as depression may have a hard time responding to the needs of their infants or toddlers.

Research validates the prevalence of depression and the power of intervention. The Early Head Start Research and Evaluation Project (Child Outcomes & Head Start Bureau, 2002), a rigorous random-assignment evaluation of 3,001 young children and families in 17 programs around the country, found a high rate of depression in Early Head Start families. Although programs did not have a statistically significant effect on reducing symptoms of parental depression, the programs did have a statistically significant positive influence on parent-child interaction and on the social, emotional, and cognitive development of infants and toddlers.

Research affirms the interconnection between emotional well-being and learning, and it recognizes the power that early care and education programs have to influence the course of young children's lives. This paper is designed to share the most current knowledge about infant mental health and to describe the practices that support positive outcomes for infants, toddlers, and their families.

WHAT IS INFANT MENTAL HEALTH?

Infant mental health practice applies knowledge of relationships to support and enhance healthy social and emotional development and to prevent and treat mental health disorders. The following definition of infant mental health was developed by a group of experts with the common understanding that observing young children's interactions with parents and other significant people is key for the assessment of emotional well-being. In addition, experts also suggest keeping in mind the infants' underlying biology that could include temperament and compromises to resilience from early trauma.

> Infant mental health is the developing capacity of the child from birth to three to: experience, regulate, and express emotions; form close and secure interpersonal 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. (ZERO TO THREE Infant Mental Health Task Force, December, 2001)

The mental and physical health of infants and toddlers is critically influenced by the daily behaviors of their caregivers. Just as hand-washing after diapering supports infant-toddler physical health, the everyday emotional and social behavior of parents and other significant caregivers influences infant-toddler mental health. The following discussion elaborates on the concepts in the definition and provides some examples of how the day-to-day behavior of early care and education staff members can support not only infants, toddlers, and parents but also one another to achieve infant-toddler emotional well-being. Stories that illustrate the discussion are in italic type and represent examples from early care and education programs. Early Head Start Performance Standards related to promoting infant mental health are listed in Box 1.

ELABORATING ON THE DEFINITION: KEY CONCEPTS OF INFANT MENTAL HEALTH

The following sections describe key concepts related to the mental health of infants. These concepts enhance what is included in the previous definition.

"Developing capacity" highlights the extraordinarily rapid pace of growth and change in the first 3 years. Although newborns experience intense feelings and are active partners in their relationships with adults, the differentiation and complexity of a young child's emotional and social development increases markedly over time. Very young infants express sadness, anger, fear, and contentment through crying, subtle smiling, and vocalizing. However, they rapidly develop more vigorous ways of expressing emotion with words, gestures, and more pronounced facial expressions.

> *Mary, a young parent, confides in her Early Head Start home visitor that she is sure her 6-week-old son, Sean, is smiling at her when he wakes up from a nap. However,*

she has heard that young babies' smiles are really a response to gas. When the home visitor points out that Sean is smiling and wriggling his feet right then in Mary's direction, she beams with delight and says "I do know my baby." The home visitor and Mary talk about the many ways Sean will be able to share feelings as he grows, including vocalizing to her, lifting his arms to request a hug, or protesting when she leaves him.

Infants and toddlers grow so rapidly that caregivers often have a hard time keeping up. A home visitor can help validate a parent's current experience and help predict changes.

Infants and toddlers initially depend heavily on adults to help them experience, regulate, and express emotions. Infants' cries and coos evoke strong reactions in their caregivers. An infant's ability to master feelings develops through give and take.

When the home visitor arrives, 3-month-old Amber is fussing after a feeding. Patrick, Amber's dad, holds her securely next to his chest and rocks her back and forth. Amber finds her fist, gently sucks on it, and quickly stops fussing. Patrick gently says, "That fist really helps." The home visitor quietly says, "And you helped her focus enough to find it." Patrick looks up with surprise and delight and says, "I guess I did."

Amber needs her dad's physical and emotional support to calm her enough so she can take part in soothing herself. Although infants' and toddlers' growing emotional mastery is rewarding, the details are subtle and can be overlooked in the hustle and bustle of everyday life. Acknowledgment from another adult can enhance the caregiver's sense of competence and can ease the intensity of the young child's dependence.

Through relationships with parents and other caregivers, infants and toddlers learn what people expect of them and what they can expect of other people. Infants and toddlers learn through what they experience within relationships and what they observe in adult's interactions with one another.

Mandy, 2 years old, walks into the toddler room firmly holding her mother's hand. Eve, the teacher, greets both of them with a smile and a "welcome." When Mandy's mom begins to take off Mandy's coat, Mandy firmly says, "No" and pouts. The teacher asks Mandy, "How was your morning?" Mandy buries her head in her mother's shoulder and peeks out at the teacher. Mom asks Mandy whether it is okay to tell Eve what they ate for breakfast. Mandy nods yes and intently follows the conversation about peanut butter and cereal. When mom tells the teacher that Mandy loved playing with a toy tiger before they left home, the teacher beams, goes to a shelf and comes back with a tiger. Mandy comes out from her mother's arms and approaches the teacher eagerly,

reaching for the tiger. Mom exclaims how wonderful it is to have tigers at home and at school, and the teacher asks Mandy whether she can help her take her coat off after they say goodbye to mama. Mandy nods yes and says "Bye bye, mom." The teacher talks about the day at school as she takes off Mandy's coat. Within a few minutes after her mom leaves, Mandy finds a place at the water table between two other children.

Mandy is learning that she will get help with transitions. And she is learning that she can feel close and secure with her mother and her teacher who talk to each other in the same respectful way they talk to her.

Infants and toddlers share and communicate feelings and experiences with significant caregivers and other children. Infants and toddlers interact with one another in emotionally meaningful ways. Parents and caregivers help young children name the feelings and understand their effect on others.

Aaron, 2 and a half, is sitting in the cozy corner, observing a teacher talking to and patting Arlo, a 3-month-old who is fussing in his infant seat. Aaron walks over, sits down next to the teacher and pats Arlo who stops fussing and looks back at Aaron intently. The teacher nods and says, "Arlo was fussing but he is happy to see you." Aaron stands up and does a little dance while Arlo watches and the teacher comments, "Arlo likes to see what you can do." Aaron smiles at the teacher, stands up a little straighter and heads for the water table to join the other two toddlers playing exuberantly with boats and baby dolls.

Aaron gets support from his teacher for expressing tenderness toward another child and is learning that he has an influence on the baby.

The drive to explore and master one's environment is inborn in humans. An essential component of infants' and toddlers' well-being is the self-esteem that grows out of mastering their bodies and the environment as well as sharing that mastery with parents and significant caregivers. Mastery in the early years generally involves multiple domains—physical, sensory, emotional, and social.

Joey, 11 months old, looks intently at a stack toy on a table. He catches his mother's eye, vocalizes, and points to the toy. She follows his gaze, walks over, and brings it down to the floor. Joey quickly crawls to the toy, smiling and vocalizing to the toy and to her. He eagerly takes the pieces apart and begins putting them back together. The home

visitor, who has been sitting on the floor next to the mom, smiles and comments on how the mother knew what Joey wanted and talks with her about how much faster his crawling has gotten over the past week.

Without words, Joey communicates what he is interested in to his attentive mother and shares his success with her. The inborn drive to explore is either fostered or dampened by interactions with others. When an adult understands what a young child wants and supports his level of engagement, the child's world expands.

Every child is a unique blend of characteristics; infants' and toddlers' developmental pathways will reflect not only their individual constitutional differences but also the contributions of their caregiving environments. Temperament, or the way an individual approaches the world, influences how tentatively or vigorously an infant might engage with a new person, toy, or situation.

Jeremy, 18 months old, is an observer who does not like change or new situations. He likes to sit quietly next to his teacher after he wakes up from his nap and watch his buddies playing. The toddler teacher talks with him about what he is observing and tells him that she has made some changes in the room during his nap. She points out that some new books and toys are on a lower shelf of the bookcase and the water table is now more in the center of the room. Jeremy listens and looks around following her description. After about 10 minutes of observing and sitting close, the teacher suggests that Jeremy choose a book and bring it back. Even though he is an accomplished walker, he crawls over to the bookcase and brings back his favorite fire engine book.

Jeremy's teacher took into account his need for continuity and the other children's need for novelty. She supports Jeremy as he "checks out" the changes and pushes him a little to get engaged. He feels more comfortable going back to an even more familiar form of getting around—crawling instead of walking—and is happy to find a book that is familiar. Understanding temperament and potential challenges (e.g., low birth weight) helps parents and staff members anticipate reactions and structure the physical environment to nurture and optimally challenge young children.

The state of adults' emotional well-being and life circumstances profoundly affects the quality of infant-caregiver relationships as well as infant and toddler mental health. Parents and other significant caregivers bring their own temperament and past experiences to

relationships. When a parent suffers from emotional distress, for example, depression, past trauma, or substance abuse, that parent's ability to read cues and respond may be compromised, making it hard to comfort a baby or join a toddler's delight and, thus, reinforcing the parent's sense of inadequacy. Intervention that addresses the parent's emotional needs as he or she interacts with his or her infant or toddler can support the relationship and enhance a parent's sense of well-being.

> *Arlene, a teen mother who has been having a hard time getting out of bed and keeping appointments, greets her home visitor at the door with a sad expression. "Kira doesn't like me. She cried when I picked her up this morning." The home visitor acknowledges how hard that is and offers to help her figure out what might be happening between them. When they enter the living room Kira, 13 months old, looks up from playing with a book and says, "Mama." The home visitor asks Arlene whether she heard Kira say "Mama." Arlene shyly asks, "Did she really?" The home visitor nods and quietly says "Yes." Arlene looks toward Kira and, with a smile, says, "Here I am." Kira maintains eye contact and smiles.*

In that deceptively simple interaction, the home visitor supports the mother and the relationship between mother and baby, enhancing the mother's ability to receive positive requests for attention, an ability that is often dampened when a parent is depressed. Kira's emotional well-being—the ability to smile and be comforted by her mother—is also enhanced.

Culture influences every aspect of human development. This broad influence affects the way that infant mental health is understood; the goals and expectations adults have for young children's development; and the childrearing practices that parents and caregivers use to promote, protect, or restore infants' and toddlers' mental health.

> *Jenny, a new mother who grew up in Russia and recently immigrated to the United States, brought Ivan, her 4-month-old baby, to the intake interview at the Early Head Start program. Ivan was awake and alert, vocalizing to both adults and wriggling in response to their smiles and words. The intake worker asked a few questions about the pregnancy and the birth and commented that Ivan seemed to be an active, engaging baby. Jenny responded nervously, saying, "Not really." The intake worker responded gently, "Sometimes it's hard to believe things are okay, and I know that, in my culture, we are not supposed to say anything too positive because it can be seen as boasting and we might be punished." Jenny visibly relaxed and said, "Yes, in my culture, we fear that the 'evil eye' will take away a baby if he is praised."*

The intake worker was puzzled at first by Jenny's initial response, and then she remembered that, with some families, including relatives in her own, speaking positively was not acceptable and created fear. Ivan was demonstrating his social and emotional well-being, but staff members would need to be sensitive to Jenny and her family's belief system and learn how they shared their positive feelings in a way that felt safe. Staff members can best support families when they are aware of and recognize the intense emotional reactions that accompany moving to a new culture.

All of the elements of the definition of infant mental health are part of daily interactions between infants and toddlers and their parents. Development occurs rapidly during the first 3 years of life, and everyone in a young child's social network works hard to keep up. The definition provides a place to begin appreciating the important role staff members play in supporting infant-toddler social and emotional well-being. One important thing to remember is that consistency in the social network of infants and toddlers helps to support all aspects of their development. When changes or disruptions occur, acknowledging and paying attention to the feelings of loss among infants, toddlers, and caregivers helps to ease transitions. The Early Head Start Performance Standards **(45 CFR 1304)** listed in Box 1 illustrate how regulations support the ways that programs integrate infant and toddler mental health into ongoing practice. The next section explores the area of infant mental health disorders.

BOX 1

Performance Standards Relevant to the Definition of Infant Mental Health

1304.21 (b)(1)(i) Grantee and delegate agencies' programs of service must encourage the development of secure relationships in out-of-home care settings for infants and toddlers by having a limited number of consistent teachers over an extended period of time. Teachers must demonstrate an understanding of the child's family, culture and, whenever possible speak the child's language.

1304.21 (b)(1)(ii) Encourage trust and emotional security so that each child can explore the environment according to his or her own developmental level.

1304.21(b)(1)(iii) Grantee and delegate agencies' program of services for infants and toddlers must encourage opportunities for each child to explore a variety of sensory and motor experiences with support and stimulation from teachers and family members.

1304.21(b)(2)(i) Grantee and delegate agencies must support the social and emotional development of infants and toddlers by promoting environment that encourages the development of self-awareness, autonomy, and self expression and

1304.21(b)(2)(ii) Supports the emerging communication skills of infants and toddlers by providing daily opportunities for each child to interact with others and to express him or herself freely.

1304.21(b)(3)(i) Grantee and delegate agencies must promote the physical skills of infants and toddlers including gross motor skills such as grasping, pulling, pushing, crawling, walking, and climbing.

WHAT ARE INFANT AND TODDLER MENTAL HEALTH DISORDERS?

Although infant-toddler mental health disorders are not a simple reverse of mental health, they reflect the other side of positive emotional growth and development.

> Infant mental health disorders are emotional and behavioral patterns that interfere significantly with very young children's capacity to meet age-appropriate cultural and community expectations for managing emotions, forming close and secure interpersonal relationships, and exploring the environment. Very young children's healthy social and emotional development may be disrupted, or begin to deviate significantly from typical patterns, because of constitutionally based individual differences, problems in the infant's or toddler's primary caregiving relationships, or the interaction between the child and aspects of the caregiving environment. Infants and toddlers with mental health disorders experience suffering, pain, and disorganization. (ZERO TO THREE, May 2002)

What alerts program leaders, parents, home visitors, and infant-toddler teachers to potential concerns about emotional well-being? An infant's or toddler's difficulty in mastering age-appropriate emotional, social, and cognitive tasks is expressed through behavior. However, the normal development of infants and toddlers often encompasses a wide range of skill levels and behaviors. Early development is not always a smooth, consistent path but may, quite normally, become a bumpy road. Occasionally, a child's skills may regress whereas, at other times, they may take quick jumps forward. Staff members can support one another and parents by carefully examining their initial concerns to distinguish any possible infant mental health problems from the wide range of normal variations in infant behavior (Zeanah & Doyle Zeanah, 2001).

Infant mental health practitioners generally agree that children's behavior should be explored further if the behavior could be described in the following ways (Parlakian & Seibel, 2002):

- Is unusual for the child or causes parents and other caregivers to perceive the child as "difficult";
- Makes satisfying interactions with others difficult;
- Is observed in multiple settings by multiple people; and
- Persists over time

In addition, mental health practitioners and researchers (Osofsky, 1999; Shonkoff & Phillips, 2000) recognize that young infants suffer pain and distress from trauma, neglect, abuse, or the abrupt loss of a caregiver. Events become traumatic when infants and toddlers are deprived of emotional safety and security within familiar relationships. An infant can

experience a dog bite, undergo a hospital procedure, or even witness domestic violence and still experience safety with a loving adult. However, when a safe emotional haven is not available, the child experiences trauma. If an infant or toddler has a recent or past history of trauma, the need for further exploration and enhanced attention is strongly recommended. Routine screening and ongoing assessment of all infants and toddlers that is done in partnership with parents can help identify concerns and address them before they become crises (see Screening and Assessment, page 22).

In contrast to typical adult behavior, an infant or young child demonstrates his or her response to internal difficulties and environmental stress through behaviors that are unaccompanied by the words that could help a parent or staff person differentiate a bad mood from a daily experience of fear. Very young children have only limited ways to signal their emotional distress: crying episodes, sleeping and eating disturbances, withdrawal from adults and peers, and behavior that adults experience as disruptive, such as temper tantrums. Therefore, a child's outward behavior of irritability, withdrawal, impulsivity, fears, and developmental delays may reflect a range of underlying problems at different points in development. Some early mental health disorders may resemble " in later life, including depression, anxiety, and traumatic stress reactions. Given this complexity, when there is concern about an infant's or toddler's mental health, assessment should take into account all the relevant areas of a child's functioning, including the following (ZERO TO THREE Infant Mental Health Task Force, May, 2002):

- Presenting symptoms and behaviors;
- Developmental history—past and current emotional, language, cognitive, motor, sensory, family, and interactive functioning;
- Family functioning and cultural and community patterns and expectations;
- The well-being of the parents;
- Caregiver-child relationships and interactive patterns;
- The infant's individual constitutional characteristics; and
- Emotional, language, cognitive, motor, and sensory patterns

When exploring the meaning of an infant's or toddler's behavior, an important concept to keep in mind is that culture (professional and familial) can affect one's perception of what is normal development or "appropriate" parenting:

> For this reason, observing and understanding children's behavior in the context of the child's home culture is strongly recommended. A solid grounding in

> infant-toddler development paired with sensitivity to and knowledge of a family's culture are the best guide for staff members' information gathering efforts. (Parlakian & Seibel, 2002, p. 18)

Programs simultaneously focus on preventing and addressing infant mental disorders and on promoting infant mental health. The next section explores how to put these concepts into practice. Box 2 lists EHS Performance Standards that relate to infant-toddler mental health disorders.

BOX 2

Performance Standards Relevant for Mental Health Disorders

1304.20 (d) Ongoing care. Grantee and delegate agencies must implement ongoing procedures by which Early Head Start and Head Start staff can identify any new or recurring medical, dental, or developmental concerns so that they may quickly make appropriate referrals. These procedures must include: periodic observations and recordings, as appropriate, of individual children's developmental progress, changes in physical appearance (e.g., signs of injury or illness) and emotional and behavioral patterns. In addition, these procedures must include observations from parents and staff.

1304.24(a)(3) Mental health program services must include a regular schedule of on-site mental health consultation involving the mental health professional, program staff and parents on how to:

(i) Design and implement program practices responsive to the identified behavioral and mental health concerns of an individual child or group of children;

(ii) Promote children's mental wellness by providing group and individual staff and parent education on mental health issues;

(iii) Assist in providing special help for children with atypical behavior or development;

(iv)Utilize other community resources as needed.

INTEGRATING PRINCIPLES OF MENTAL HEALTH INTO YOUR PROGRAM

Research shows that supportive relationships have a tangible and long-term influence that contributes to optimal social, emotional, and cognitive development of infants and toddlers (Zeanah & Doyle Zeanah, 2001). As a child grows, supportive relationships with parents and caregivers shape his or her self-image and provide that child with the resilience he or she needs to face new challenges. In addition, nurturing, sensitive adult-child interactions are crucial for the development of trust, empathy, compassion, generosity, and conscience. These relationships are far-reaching. Research has shown that relationships provide a context for supporting the development of children's curiosity, self-direction, persistence, cooperation, caring, and conflict resolution skills (Parlakian & Seibel, 2002).

SIX PRINCIPLES THAT SUPPORT INFANT AND TODDLER MENTAL HEALTH

Six research-based, best practice principles offer a solid framework with which to explore

various strategies your program can use to strengthen its capacity to support the mental health needs of very young children. The following six building blocks, or "ways of being," form the foundation for successfully promoting infant and toddler mental health, preventing serious emotional disturbances, and intervening when disorders are present.

Observe infant-toddler interactions in multiple settings to identify strengths and potential next steps. Infants and toddlers tell us about their strengths and vulnerabilities through their behavior with others. The context or environment can influence behavior. Therefore, one needs to observe infants and toddlers in the home, during socializations, in the classroom, and on the playground.

Keep in mind the multiple, potentially interacting origins of an infant's or toddler's behavior, namely, biology (including temperament), developmental stage, environment, and goodness of fit between the baby as well as his or her family and the child-care setting. Understanding a young child's behavior requires incorporating information about all domains of development (social, emotional, cognitive, and physical) and prior history. The meaning of behavior is not always obvious and cannot be assumed. For example, a 6-month-old who cries during transitions to child care at the beginning and the end of the day might be expressing a new understanding about separation or might be a child who generally has a hard time with transitions, prefers to take things slowly, and might be reacting to quick separations and reunions. Another 6-month-old who happily enters and leaves child care may feel supported by his or her parents spending time in the center in the morning and evening and may also be a child who generally adapts easily to new situations and people.

Identify and share observations of strengths in the infants' and toddlers' relationships with their parents and teachers. Focusing on strengths increases parents' and teachers' awareness of their own positive responses and provides a base from which to think about potential next steps. Building on strengths does not mean avoiding risks or ignoring them. Focusing on positive interactions promotes more positive interactions and is one successful way to decrease problematic exchanges.

Listen to parents. A parent's relationship with his or her child is the cornerstone for that child's development. Parents know their children best. In all but the most extreme situations,

even parents who are challenged emotionally or medically want the best for their children. A parent knows the young child's history, his or her developmental process, and the complexity of daily and weekly life.

Listen to staff members. Infant–toddler teachers and home visitors learn about infants, toddlers, and parents through daily or weekly interactions. Staff members' observations and experiences are valuable in helping to develop a full picture of the young child and his or her relationships.

Provide regular supervision that allows staff members to reflect on their observations and feelings. Relationships are essential for all human growth and development. Supervisory relationships are the vehicle for the intellectual and emotional development of staff members. In turn, staff members' relationships with parents and young children are key in supporting the growth and development of those two groups. Staff members can most effectively give support when they receive support.

AN INTEGRATED APPROACH TO COMPREHENSIVE SERVICES

How do the systems you are planning or are already using promote infant-toddler mental health, prevent the occurrence of mental health disturbances or disorders, and treat them when they are present? The following sections explore the program elements of screening and assessment, curriculum and individualization, environments, partnerships with community mental health providers, management systems, and human resources. While considering these elements, keep in mind that the emotional well-being of infants and toddlers is linked to the emotional well-being of parents, teachers, home visitors, supervisors, managers, and leaders and to the degree that their relationships support one another.

SCREENING AND ASSESSMENT

> *Developmental assessment is a process designed to deepen understanding of a child's competencies and resources, and of the caregiving and learning environments most likely to help a child make fullest use of his or her developmental potential. (Greenspan & Meisels, 1996, p. 11)*

Screening and assessment of infants' and toddlers' social and emotional well-being support the functions of promotion, prevention, and intervention. Box 3 lists the EHS Performance Standards that are relevant for screening and assessment of social and emotional well-being.The process is most helpful when both strengths and concerns are identified. The screening process is used to determine whether social and emotional as well as all other developmental skills are progressing as expected or whether cause for concern is warranted and further evaluation is necessary.

Using tools that take into consideration the wide variety of backgrounds, languages, and customs of participating families will ensure that the information is accurate and will build the vital connection between the program and the families. Given the complexity of infant and toddler development, assessment of mental health is only one part of the ongoing process to identify each infant's and toddler's unique strengths and needs in all domains of development.

The mental health of parents is an important factor that contributes to the emotional well-being of infants and toddlers. Providing social and emotional support to parents and addressing parental mental health can support positive child outcomes. One way EHS programs address parental needs is to incorporate during the intake process a formal screening instrument, using various measures of depression, to assess parental depression (see Additional Resources section).

Strategies for integrating screening and assessment include the following:

- Be systematic. Include a method for documenting observations; a process for planning when, where, and how screenings and assessments will be accomplished; a process for

discussing outcomes of screenings and assessments; and a process for tracking change over time, including the outcomes of any referrals.

- Use parents as partners in screening and assessment. Check with parents about whether a child's behavior in the program is similar to behavior at home. Incorporate parents goals and expectations into assessment and ongoing evaluation.
- Use multiple sources of information for screening, assessment, and evaluation that will help identify strengths and predict next steps. Some methods for gathering information include observations, verbal or written reports, work samples, rating scale checklists, audiotapes, videotapes, and photos.
- Include in screenings, assessments, and evaluations

— observations of children's behavior in interactions with parents, staff members, and other significant people who regularly interact with the child;

— health and developmental history;

— information about prenatal care and childbirth as well as timelines of when the child reached social and emotional developmental milestones;

— questions for parents about their social and emotional well-being and supports for ongoing evaluation.

- Consult with your infant mental health consultant about how to strengthen your capacity to meet the mental health needs of parents as well as infants and toddlers, including identifying assessment instruments or procedures to help answer questions that cannot be answered by observation or parent report alone.

BOX 3

Performance Standards Relevant for Screening and Assessment of Social and Emotional Well-Being

1304.20(b) Screening for developmental, sensory, and behavioral concerns.

(1) In collaboration with each child's parent, and within 45 calendar days of the child's entry into the program, the grantee and delegate agencies must perform or obtain linguistically and age appropriate screening procedures to identify concerns regarding a child's developmental, sensory (visual and auditory), behavioral, motor, language, social, cognitive, perceptual, and emotional skills. To the greatest extent possible, these screening procedures must be sensitive to the child's cultural background.

(2) Grantee and delegate agencies must obtain direct guidance from a mental health or child development professional on how to use the findings to address identified needs.

(3) Grantee and delegate agencies must utilize multiple sources of information on all aspects of each child's development and behavior, including input from family members, teachers, and other relevant staff who are familiar with the child's typical behavior.

CURRICULUM AND INDIVIDUALIZATION

Infant and toddler mental health is woven into all aspects of children's learning and growth. Determining how well an infant-toddler curriculum for any early care and education setting (home-based, center-based, family child care) incorporates sound infant-toddler mental health practices requires a process that involves reviewing the written curriculum and observing interactions between staff members and children as well as between parents and children. Box 4 highlights the Performance Standards related to curriculum.

Strategies for integrating curriculum and individualization include the following:

- Develop a written curriculum philosophy that identifies the key role of relationships (between parents and children, parents and staff members, and among staff members within the program) in the overall curriculum and in individualizing efforts for each child. The goals should reflect the key elements in the definition of infant mental health: developing close and secure relationships, experiencing and regulating emotions, exploring the environment, and learning in every domain of development.
- Invite parents' observations of their children, and incorporate those observations into the curriculum and individualization for home-based, center-based, and family child-care options.
- Encourage parents to participate in reviews of their children's progress and in problem-solving sessions about social, emotional, cognitive, or physical concerns.
- Share with the parents how home visitors and infant-toddler teachers see the curriculum promoting key mental health outcomes for their infants and toddlers, including forming close trusting relationships, demonstrating curiosity and motivation to learn, solving problems, achieving self-regulation, and communicating.
- Incorporate information from the social and emotional screening and assessment into the individualized curriculum for each child.
- Use home visits to families with infants and toddlers in child care as an opportunity for individualization and for supporting the parent-child relationship. Staff visits to the home support the link between home and child care for infants and toddlers. Most working parents appreciate an opportunity to affirm and review their infants' relationship to them and to child care as part of their expanded social network.

BOX 4

Definition of Curriculum in the Head Start Program Performance Standards

1304.3(a)(5) Curriculum means a written plan that includes the goals for children's development and learning; the experiences through which children will achieve these goals; the roles that staff and parents will play in helping children achieve goals; and the materials needed to support the implementation of the curriculum.

ENVIRONMENTS

The configuration of center-based environments can either promote or undermine infants' and toddlers' mental health and the quality of their interactions with teachers, parents, and one another. Well-designed environments (a) encourage positive interaction and support infants' and toddlers' ability to regulate their emotions, explore the environment, and master tasks and (b) do not make excessive demands on young children's coping skills. A well-designed space is comfortable for infants and toddlers with different temperaments as well as for their teachers and parents. In this kind of space, children can play together or separately and find a place to comfort themselves or be comforted when they are angry or sad. Box 5 lists the EHS Performance Standards that are relevant for the configuration of center-based environments.

Poorly designed environments are stressful. Teachers are concerned about the safety and well-being of children, and their saying "no" occupies a great deal of teacher energy and attention. The time teachers spend monitoring keeps them from interacting with an infant or toddler in ways that build self-esteem (e.g., acknowledging that a child is mastering a skill such as climbing or helping a child elaborate on a skill). Infant mental health consultants can help programs assess the extent to which the physical environment is promoting teacher-child interaction as well as infant-toddler social and emotional well-being.

Strategies for integrating well-designed environments include the following:

- Help create environments for same-age or mixed-age groups that (a) support infants' and toddlers' ability to build strong relationships with their parents, teachers, and peers and (b) support their ability to self-sooth, master their environment, and express the full range of emotions, including exuberance, sadness, anger, and fear.
- Observe current center-based environments, focusing on the following key questions.

— Do the teachers follow the lead of infants and toddlers and engage in give-and-take with toys, words, smiles, and hugs?

— Do infants and toddlers vocalize with one another? Do they have room to play alone

and together? Are enough toys and equipment available so children can generally play without having to line up or share the most attractive and beloved toys?

— Can infants and toddlers explore safely?

— Do the furnishings promote relaxation?

— Is comfortable space accessible for infants and toddlers to enable them to regulate their emotions (e.g., find comfort when sad or gain control when feeling angry or frightened) with a teacher or on their own?

— Does the level of stimulation from noise and light support or challenge infants' and toddlers' ability to focus on tasks or fall asleep?

— Is equipment such as sand or water tables available for sensory play?

— Does the space welcome parents and support parent-child interaction at the beginning and the end of the day?

— Are center-based rooms divided? Particular challenges emerge when one room is divided to create space for more than one group of eight. Although an adult may see moveable cribs or low shelves as room dividers, an infant or toddler is more likely to relate to them as toys to push or structures to climb, increasing the need for teachers to monitor safety by prohibitions and decreasing the opportunity for positive interactions.

— Do center-based environments use natural light?

— Do playground spaces promote a connection with nature?

- During home visits, support parents in arranging and using the environment to meet their needs and the needs of their of infants and toddlers. For example, in a home, the sink or bathtub can provide opportunities for sensory play. You might use the questions outlined in the preceding list and help families predict changes in development that require "baby proofing" or rearranging furniture to allow for safe, fuller exploration as an infant gains more mobility.
- In home-based programs, use the furnishings and material available to help parents enhance space that supports interaction and connection. For example, parents can create a cozy corner for snuggling or set up a shelf in the kitchen with toys so the parent and young child can be together during meal preparation.
- In programs that provide a regular group experience for parents and their infants and toddlers, create a physical space that allows parents, infants, and toddlers to sit together on the floor or at low tables.

BOX 5

Performance Standards Relevant for the Configuration of Center-Based Environments

1304.52(g)(4) Grantee and delegate agencies must ensure that each teacher working exclusively with infants and toddlers has responsibility for no more than four infants and toddlers and that no more than eight infants and toddlers are placed in any one group. However, if State, Tribal, or local regulations specify staff:child ratios and group sizes more stringent than this requirement, the State, Tribal, or local regulations must apply.

1304.53(a)(1) Grantee and delegate agencies must provide a physical environment and facilities conducive to learning and reflective of the different stages of development of each child.

1304.53 (a)(3) The center space provided by grantee and delegate must be organized into functional areas that can be recognized by the children and that allow for individual activities and social interactions.

1304.53(a)(4) The indoor and outdoor space in Early Head Start or Head Start centers in use by mobile infants and toddlers must be separated from general walkways and from areas in use by pre schoolers.

1304.53(a)(5) Centers must have at least 35* square feet of usable indoor space per child available for the care and use of the children (i.e., exclusive of bathrooms, halls, kitchen, staff rooms, and storage places) and at least 75 square feet of usable outdoor play space per child.

1304.53(a)(9) Outdoor play areas at center-based programs must be arranged so as to prevent any child from leaving the premises and getting into unsafe and unsupervised areas. .

1304.53(a)(10)(xiv) Toilets and handwashing facilities are adequate, clean, in good repair, and easily reached by children. Toileting and diapering areas must be separated from areas used for cooking, eating, or children's activities.

1304.53(b)(1) Head Start equipment, toys, materials, and furniture. Grantees and delegate agencies must provide and arrange sufficient equipment, toys, materials and furniture to meet the needs and facilitate the participation of children and adults. Equipment, toys, materials, and furniture owned or operated by the grantee or delegate agency must be (i) supportive of the specific educational objectives of the local program; (ii) supportive of the cultural and ethnic backgrounds of the children; (iii) age appropriate, safe, and supportive of the abilities and developmental level of each child served, with adaptations, if necessary, for children with disabilities; (iv) accessible, attractive, and inviting to children; (v) designed to provide a variety of learning experiences and to encourage each child to experiment and explore; (vi) safe, durable, and kept in good condition; and (vii) stored in safe and orderly fashion when not in use.

* EHS programs have found that infants and toddlers generally require more space.

PARTNERSHIPS WITH COMMUNITY MENTAL HEALTH PROVIDERS

Early care and education programs can best serve infants and toddlers and their families when the program can make referrals to community agencies that have a professional on staff who is trained in infant-toddler mental health. Intervention is likely to focus on supporting the relationship between an infant or toddler and the parent who is the child's primary caregiver. However, in many instances, infant mental health practitioners will also observe and consult with other significant people (e.g., infant-toddler child-care teachers). Another infant mental health approach is to explore how parents' experience of being parented influences their interactions with their own infants and toddlers. Box 6 lists the EHS Performance Standards that are relevant for partnerships with community mental health providers.

When parents are referred for mental health services to address depression or other mental health issues such as thought disorders or affective disorders, the therapy may not incorporate talking or thinking about their young children. Therefore, early care and education programs need to encourage these mental health practitioners to routinely help adults think and talk about relationships with their children. When agencies incorporate that perspective, parents can better integrate the benefits of mental health services into daily interactions with their young children.

Substance abuse can be another burden for parents dealing with mental health issues. When parents suffer from substance abuse, community agencies that understand the special needs of parenting are the most helpful. For example, if your community has a detoxification program that can house both a mother and her baby, their relationship can be sustained and enhanced. If your community does not have programs that can serve parents and children, then developing this type of program might become a community project. Early care and education programs are often in the position of sharing information about parenting with community agencies that are focused on recovery.

Strategies for integrating partnerships include the following:

- Plan meetings between your agency leaders and mental health and substance abuse recovery agency leaders (or mental health or substance abuse practitioners) to learn more about their approach to infant-toddler mental health and to adult mental health.
- Develop formal, written agreements between your program and agencies to which you refer, which specify systems of communication, tracking, referral, and confidentiality.
- Discuss confidentiality with parents and the value of sharing information; however, programs must respect a parent's decision to have information shared or not shared with the staff.

- Develop a system for referral that includes documentation and follow-up. A depressed mom may need support to follow through with a referral.
- Ask parents how the referral worked, and develop a profile or assessment of the community agencies or individuals to whom you refer the parents.
- Enlist health advisory committees and your mental health consultant to encourage local mental health practitioners to pay attention to parent-child relationships even when they are providing adult individual psychotherapy.

BOX 6

Performance Standards Relevant for Community Partnerships

1304.41(a)(2) Grantees and delegate agencies must take affirmative steps to establish ongoing collaborative relationships with community organizations to promote the access of children and families to community services that are responsive to their needs, and to ensure that Early Head Start and Head Start programs respond to community needs, including:

(ii) Mental health providers.

1304.41(b) Each grantee directly operating an Early Head Start or Head Start program, and each delegate agency must establish and maintain a Health Services Advisory Committee which includes Head Start parents, professionals, and other volunteers from the community. Grantee and delegate agencies must also establish and maintain such other service advisory committees as they deem appropriate to address program service issues such as community partnerships and to help agencies respond to community needs.

MANAGEMENT SYSTEMS

Relationships are the foundation for infant-toddler mental health. Therefore, communication systems that support verbal and written give-and-take about mental health between parents and staff members, staff members and supervisors, and staff members and managers best support the social and emotional well-being of infants, toddlers, and their families. As leaders, the managers and directors set a tone and, through that tone, communicate how safe it is to talk about emotional well-being and about mental health challenges. Box 7 lists the EHS Performance Standards related to management systems.

Confidentiality, the assurance that information shared with a supervisor or with a group will not go beyond the group, is essential for creating a safe environment for sharing feelings and past experiences. However, practitioners must be honest about the limits of confidentiality when concerns arise about a person's safety and well-being or about the safety of others. Setting ground rules with staff members and revisiting them periodically is important to clarify the communication system and how it works.

Strategies for integrating management systems include the following:

- Provide support to staff members that enables them to talk about the intense emotions that are often evoked when working with infants, toddlers, and parents. Fundamentally "naming" emotions and creating opportunities to talk about them are effective ways to start and sustain a dialogue. Discussions can occur within existing communications systems such as staff meetings and management meetings.
- Incorporate mental health discussions into written and verbal exchanges with parents in the parent's preferred language. Translations of what someone says about feelings or social interaction often miss nuances and can therefore be misleading.
- Incorporate parents into regular meetings about infants and toddlers and families. Talking with parents rather than about parents provides staff members with more information and builds the relationship between a family and a program.
- Document in writing the number of referrals to mental health agencies to help with planning and ongoing assessment.
- Have professionals from diverse backgrounds (e.g., child development, education, occupational therapy, social work, nutrition, family systems) meet together to ensure the best plans for promoting well-being and for intervening when difficulties arise. These meetings are particularly important given the multiple realities that affect infant and toddler development.

BOX 7

Performance Standards Relevant for Management Systems

1304.24 Child Mental Health Services. The objective … is to build collaborative relationships among children, families, staff, mental health professionals and the larger community, in order to enhance awareness and understanding of mental wellness and the contribution that mental health information and services can make to the wellness of all children and families.

1304.24(a)(1) Mental Health Services. Grantee and delegate agencies must work collaboratively with parents by:

(i) Soliciting parental information, observations, and concerns about their child's mental health;

(ii) Sharing staff observations of their child and discussing and anticipating with parents their child's behavior and development, including separation and attachment issues;

(iii) Discussing and identifying with parents appropriate responses to their child's behavior;

(iv) Discussing how to strengthen nurturing, supportive environments, and relationships in the home and the program;

(v) Helping parents to better understand mental health issues;

(vi) Supporting parents' participation in any mental health interventions.

1304.51(c) Communication with families.

(1) Grantee and delegate agencies must ensure that effective-two-way comprehensive communications between staff and parents are carried out on a regular basis throughout the program year.

(2) Communication with parents must be carried out in the parent's primary or preferred language or through an interpreter, to the extent feasible.

1304.51(e) Grantee and delegate agencies must have mechanisms for regular communication among all program staff to facilitate quality outcomes for all children and families.

1304.40(f) Grantee and delegate agencies must ensure that the mental health education provides, at a minimum:

(i) A variety of group opportunities for parents and program staff to identify and discuss issues related to child mental health;

(ii) Individual opportunities for parents to discuss mental health issues related to their child and family with program staff;

(iii) The active involvement of parents in planning and implementing any mental health interventions for their children.

HUMAN RESOURCES

Program leaders—directors, executive directors, and managers—are pivotal in providing emotional support and direction for their programs. Often, their needs for support and a safe place for self-reflection are overlooked. Professionals in the field of early care and education know that, when they experience supportive relationships themselves, they can more easily provide them to others. Therefore, strengths-based consultation for the leader provides a solid foundation for supportive supervisory relationships. Box 8 lists the EHS Performance Standards that relate to human resources.

Supervision provides an opportunity for staff members to experience support and connection, to affirm their skills and capacities, and to think about next steps in their own development. Making room for self-awareness and the feelings that may arise from working closely with infants and families is an essential element of supervision. Focusing on interactions that are going well builds a solid base from which to work and meet challenges as they arise. Therefore, another key element of supervision is observing in the classroom or on home visits and providing positive feedback.

Regular feedback that helps staff members "see" their effective interactions with infants and toddlers as well as with their families supports ongoing training and development. Although responding to cues and following the lead of infants, toddlers, and parents might sound like a simple job, it is actually complicated and subtle. Just as being a parent can be isolating, being a home visitor or a center-based teacher can feel lonely. Supervision connects the staff to the social support network of the program.

Strategies for integrating human resources include the following:

- Supervision
  - Provide reflective consultation for the program leader.
  - Provide staff members with regular supportive-reflective supervision that focuses on relationships and leaves room for feelings.
  - Use supervisory meetings to introduce and apply skills in observation, self-awareness, and responsiveness to parents and young children.
  - Consider the extent to which staff meetings include opportunities for staff development and peer mentoring in infant and toddler mental health.
  - Establish an individual development plan with each staff person that builds on his or her strengths in infant and toddler mental health and that identifies training and other growth opportunities for specific areas of development.
  - Ask staff members to identify the social and emotional strengths of the children and parents with whom they work; use these strengths as a basis for discussing individual and family growth and development.
- Recruitment and Training of All Staff Members

— Recruit staff members who are skilled in infant-toddler mental health and children's social and emotional development.

— Identify broad skills (e.g., observation, providing strengths-based feedback, listening to parents) that all staff members in the program should possess. Ensure that these skills are represented in not only job descriptions but also performance evaluations. During the hiring process, ask a prospective staff member to do an exercise in which he or she observes infants and toddlers and shares those observations.

— Provide ongoing regular feedback to every level of the staff that identifies and explores each staff person's competencies and skills.

— Provide training to the entire staff—direct-service, support, and administrative staff members—on how they, as individuals, can promote children's and families' social-emotional development. Recognize when staff members follow through and provide positive feedback in supervision.

— Provide staff members ongoing training in

- observing and differentiating observations from "inferences" or conclusions.
- understanding the meaning of behavior.
- developing awareness of feelings and how each individual's past history may affect interactions with parents and children.
- forming strong relationships, including establishing comfortable professional boundaries.
- empathizing with and understanding a parent's perspective.

• Recruitment of Mental Health Consultants

— Look for mental health consultants who have specific training in infant mental health. Given that infant mental health training can occur in diverse settings, ask about academic and professional or postgraduate training to give you the clearest sense of the person's training.

— Set up a real or videotape situation during the interview process and ask the candidate to observe and share those observations with your hiring group. Observing and sharing observations are critical part of the role.

— Include parents in the hiring process to ensure finding a mental health consultant who can translate social and emotional well-being in a way that engages parents. Parents' responses to a potential mental health consultant are key in the hiring process.

BOX 8

Performance Standards Relevant for Human Resources

1304.52 (a)(1) Grantee and delegate agencies must establish and maintain an organizational structure that supports the accomplishment of program objectives. This structure must address the major functions and responsibilities assigned to each staff position and must provide evidence of adequate mechanisms for staff supervision and support

1304.52 (d)(4) Mental health services must be supported by staff or consultants who are licensed or certified mental health professionals with experience and expertise in serving young children and their families.

CHALLENGES

The challenges you meet will vary depending on numerous factors, including whether you serve an urban or a rural area, are part of a community with mental health resources, hire outside mental health consultants, or incorporate mental health professionals into the program. However, some challenges are universal. Flexibility and an ability to change are important characteristics in successfully meeting any challenges. The following sections describe some of the more universal challenges that early care and education programs face as well as some ideas for meeting them.

Responding to staff turnover. Staff members in early care and education programs leave for many reasons—to advance their careers within the field, raise a family, return to school, change careers. Although salaries are certainly problematic in the field, research shows that training and staff development, including regular supportive supervision, help retain staff members. One recruitment strategy is to provide internships for students in high school, community colleges, 4-year colleges, and graduate schools. Students who work as interns and are trained by you can be an excellent source for new staff members. However, supporting staff people to train and mentor students is potentially a challenging part of this solution!

Finding infant-toddler mental health consultants and infant-toddler mental health providers. Infant-toddler mental health is a new but growing specialty. Several states have Infant Mental Health Associations, and these can help you locate consultants or therapists. In addition, a growing number of postgraduate training programs for infant mental health providers can be helpful in finding trained people.

Changing community financial resources. When states experience budget crises, financial support for mental health services to children and adults may be cut. It is essential to develop relationships with local and state departments of mental health to learn about changes and, at times, provide valuable information for advocacy.

Strengthening multidisciplinary relationships. Bringing together professionals from different disciplines—child development, mental health, nutrition, and health—requires a willingness to learn and to teach. Keeping the child and family in mind can help bridge the

differences. In addition, trainings and staff meetings that help each discipline describe its "culture" and skills, which brings people closer together.

APPLICATIONS IN THE FIELD

How do the concepts and strategies described in this paper influence the experiences of infants and toddlers? The following vignette and discussion illustrate how one program influenced the mental health of a toddler. In this real-life example, the importance of promotion, prevention, and early intervention are woven together. The italic print is used to highlight the telling of the story by program staff members and the observations of an outside consultant. The program provided permission to share the vignette and the names of individuals were changed to ensure anonymity.

> *Daniel, a 15-month-old toddler, and his foster-adoptive parents were referred to an Early Head Start center-based program by the state child welfare agency. The brief history that accompanied Daniel described multiple placements. When Daniel was 3 months old, he and his older sister were removed from their biological parents after allegations of extreme neglect. A 9-month placement in a foster home was severed after allegations of abuse were substantiated with the older sister. After 3 months in a respite home, Daniel was placed in a foster-adoptive home and referred for child care.*
>
> *From the first day of his enrollment in the center-based option, the infant toddler teachers observed that he did not react when his foster-adoptive parents dropped him off. During the course of the child-care day, Daniel did not respond emotionally to the other infants or toddlers nor did he reach out to the teachers. Although the teachers' first impression was that he appeared to be a child who "went with the flow," they discussed their discomfort and wondered how much of Daniel's approach to life might be understood as his temperament and how much might be the result of withdrawing to cope with his past experiences.*
>
> *The lead teacher generally encouraged staff members to be attentive and respond to infants' and toddlers' efforts to initiate interaction. Daniel did not seem to care who interacted with him. Although he walked, he got places in the room by crawling. He vocalized occasionally, rarely toward a teacher or child. The teachers were concerned that Daniel did not pick up or move toys the way toddlers generally do but held a toy in his hand tightly in front of his eyes and stared at it intently. By the end of the second week, he still didn't seem to care who interacted with him. The lead teacher asked for a consultation with the mental health and disabilities coordinator for the Head Start, Early Head Start services and the infant-toddler child-care programs that are part of their community action agency. The teacher wanted help in thinking about potential next steps in the classroom and in how to talk with Daniel's foster parents about her concerns, and she wanted him to have a full screening as soon as possible, well before the 45-day limit.*

The lead teacher's concern came from observing Daniel's extremely low level of interaction with staff members and with other infants and toddlers—a level lower than what the teacher knew was generally expected from a 15-month-old. Through conversations with her supervisor, the teacher reflected on her observations of Daniel, information from his past history, and her own knowledge of development to develop an "educated guess," or hypothesis, that Daniel was experiencing emotional distress as well as language and motor delays. However, she also wanted to proceed cautiously and observe him in the home to develop a full picture of Daniel's temperament and behavior.

The following is an observation of Daniel at 18 months of age and an excerpt from an interview with his teacher 3 months after his entry into the program.

Observation

Daniel and his foster father arrive at the center with Daniel firmly grasping his father's hand. His father helps him put his things in his cubby and hang up his jacket. Daniel smiles at his teacher and watches as his father and his teacher talk. When his father says good-bye, Daniel frowns and fusses as he leaves. The teacher reassures him that "Daddy will be back after work." He sits in the teacher's lap for a few minutes, calms down, and nods when the teacher asks if he is ready to wash his hands before breakfast. He washes his hands and then sits at a low table, eating breakfast with his teacher and two other toddlers. He vocalizes to the lead teacher and eagerly observes the other toddlers as they eat and talk. He vocalizes to them and to the teacher. The teacher repeats vocalizations and forms them into words "hi," "juice," "more." When he is done eating, he signals "all done" with his hands, and the teacher responds, "Are you done, Daniel?" He nods yes, and she asks, "Would you like to get down and play?" He nods eagerly with an animated expression.

Daniel crawls into another section of the room where another teacher is feeding and comforting two infants. Daniel picks up a Kermit frog puppet, stands, and walks, holding the puppet out toward the teacher and vocalizing "ermit" and the teacher repeats, "Kermit, the frog." He walks, puts the puppet down, and picks up an octopus toy and shows it to the teacher, vocalizing "ottopi" and the teacher affirms, "Yes, it's an octopus." Daniel crawls back to the other section of the room, peeks around, makes eye contact with the lead teacher, and says "Hi." She smiles warmly and says, "Hi Daniel, are you exploring?" He comes back into the other section of the room, stands, and finds a wand on a table and picks it up and shows it to the observer. When one of the babies cries, he walks over and pats him gently with the help of the other teacher.

Interview

The teachers relate that after 2 months in the program, Daniel began consistently noticing and expressing some sadness when his parents dropped him off and was able to receive comfort from his primary teacher. After 3 months, he began to defend his

toys and territory. Daniel's receptive language skills tested within normal limits while his expressive skills were 2 standard deviations below the norm. The staff report that Daniel is demonstrating more "rhythms" of spoken language and vocalizes to them consistently. Although Daniel does still dangle objects, he is moving toys from one hand to the other. His attention span is the strongest for reading. The lead teacher reported that she reads with him for 45 minutes at the end of every day.

Daniel, after 3 months of being part of consistent, nurturing relationships at home with his foster-adoptive parents and in child care, was able to actively participate in relationships and explore his environment with vitality. The concept of "developing capacity" supports the wisdom of intervening as early as possible to enhance the course of development. Daniel's "constitution," his vigor and tenacity combined with his easygoing manner, allowed him to access the resources in his new environment and to move toward getting back on track developmentally.

Daniel flourished because he was part of a strong relationship network. What were the roles of the staff members in bringing about change? The center-based teachers were pivotal in creating meaningful relationships with Daniel through daily interactions. The infant mental health and disability manager provided regular supervision and feedback for the site manager supervising the teachers and helped staff members see small positive changes such as Daniel seeking eye contact. Reflecting on changes and celebrating small steps helped the teachers remain steadfastly optimistic in their response to Daniel's slow but steady progress.

In addition, the mental health and disabilities manager's monthly home visits with the foster-adoptive parents helped to identify the parents' concerns about language and to strengthen Daniel's relationships with his parents and his siblings. The visits built trust between the family and the program. That trust helped the parents feel comfortable with doing a screening within the first 45 days and with participating in on-going assessment of Daniel's well-being.

Through the on-going assessment process, the foster-adoptive parents shared their concerns about Daniel's new protests and tears when they said good-bye. The parents wondered whether this new behavior was a sign that their quiet, easygoing toddler was becoming a difficult child. The mental health manager helped the parents see that Daniel's protests and tears were a sign of how much they mattered to him—a milestone in his emotional development. In addition, she could help them celebrate Daniel's awakening emotions and understand that his sadness, anger, and joy had been dampened by painful experiences of abuse and neglect. Daniel's capacity to express the full range of emotions, including protests and tears, was evidence of mental health.

Your program has its own unique stories to tell. Perhaps this vignette will inspire you to write about one or more of those stories and share them with your board and with your community. And whenever possible, celebrate the daily work, remembering that every small step is part of the unfolding development of young children, parents, and staff members.

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LIST OF RESOURCES

This list is meant to offer you a place to begin to search for resources on a variety of topics related to infant, toddler and family mental health. It is not intended to be a complete and exhaustive list. Please add to it as you explore this field.

PRINT RESOURCES

Screening and Assessment

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ON-LINE RESOURCES

The following is a list of internet resources containing information related to infant/toddler health, mental health and development. There are also a few sites listed with information and resources for parents. Most have links to other related and useful websites.

Bright Futures
www.brightfutures.org
Current and emerging preventive and health promotion for infants, children and families. This site features guidelines for health supervisors; a section for developmental issues and strengths in the infancy period; and related publications.

Mental Health Tool Kit at the HSIPC
http://www.headstartinfo.org/infocenter/mentalhealth/mh_tlbok.htm
This tool kit provides links to a variety of useful web sites related to mental health.

National Center for Education on Maternal and Child Health
www.ncemch.org
NCEMCH provides national leadership to the maternal and child health community in three key areas – program development, policy analysis and education, and state of the art knowledge – to improve the health and well-being of the nation's children and families.

Off to a Good Start: The Child Mental Health Foundations and Agencies Network (FAN).
www.nimh.nih.gov/childhp/fdnconsb.htm

Program for Infants, Toddlers and Caregivers (PITC)
www.pitc.org
PITC was developed by West ED Center for Child and Family Studies, in collaboration with the California Department of Education Child Development Division. This site offers power point presentations on infant curriculum, brain development, attachment, language, literacy, infant play, etc., as well as information and resources on PITC and links to other relevant sites.

Resources for Infant Educarers

www.rie.org

Resources for Infant Educarers (RIE) teaches a unique philosophy and methodology in caring for infants. The teachings of Magda Gerber, incorporating respect, quality time, patience, and observation are offered in the form of training classes, books and videos. The site is a resource for parents and professional caregivers.

ZERO TO THREE

www.zerotothree.org

This web site offers information on strengthening and supporting families, practitioners, and communities to promote the healthy development of babies and toddlers, as well as links to other relevant sites.

PATHWAYS TO PREVENTION: A comprehensive guide for supporting infant and toddler mental health

No matter how mental health services are delivered, the understanding of mental health is the same: prevention first, promotion always, and intervention when necessary.

(White-Tennant & Costa, 2002, p. 6)

EARLY HEAD START

NATIONAL RESOURCE CENTER @ ZERO TO THREE