

EARLY HEAD START TIP SHEET

No. 22

Infant/Toddler Mental Health Services, May 2010

What does Infant Mental Health (IMH) mean? And, how do EHS programs implement quality IMH services?

Response:

Through home visits, center-based, and/or family child care, Early Head Start (EHS) and Migrant and Seasonal Head Start (MSHS) programs are uniquely positioned to offer support to families and directly impact the mental health of infants, toddlers and their parents. Through caring, long-term relationships, staff can provide supportive services that help families meet the mental health needs of parent and child.

Unfortunately, the term **infant mental health** can be confusing. For some, the term translates only to “mental illness.” For others, the idea that babies and toddlers have the capacity to experience complex emotions is not easy to comprehend. People hold a broad range of views about how babies “are” during the first years of their lives. Some people think that babies don’t require much from their caregivers, needing little more than nourishment, clean diapers, and clean clothes to thrive during the first part of their lives. Another belief is that babies are like sponges, absorbing the stimuli from the world, but not necessarily engaging in the world. Depending on your view, it might be difficult to imagine that babies and toddlers can be fully engaged in complex relationships and can have strong emotional responses to their experiences and their caregivers. The mental health of infants and toddlers is likewise a complex domain of unfolding development, which in order to define it requires the consideration of a number of variables including, but not limited to, the following:

Relationships: Scientific research has demonstrated that babies are born with brains that are wired for engaging in relationships with adults¹. Like adults, babies have emotional responses to those relationships. Babies actively seek out and engage with the adults who care for them. Supportive relationships with adults, particularly primary caregivers, “are crucial both for physical survival and for healthy social-emotional development”². In order to understand the mental health of a child, one needs to first consider the baby’s experiences over time within the context of those important relationships with parents and other caregivers.

Child Development: Another variable adding to the complexity of understanding infant mental health is the rapid growth and development of children age birth to three. A 2-month old looks different and has very different experiences than a 12-month old. As children grow and develop their ability to communicate and express themselves changes. The lens they use to view the world expands along with their view of themselves in the world. Not surprisingly, their relationships with caregivers are likely to be impacted by that change as well.

Culture: Yet another factor to take into account when attempting to understand the mental health of young children is the cultural context of their experience. Families live in a variety of communities, with varying values and beliefs, express themselves and their beliefs in different ways, and engage in child rearing practices that are often influenced by their culture and beliefs. It is imperative to take cultural context into account when developing an understanding of infant mental health.

¹ National Research Council and Institute of Medicine, 2000.

² Parlakian & Seibel, 2002, 1.

Definition of IMH

Infant mental health has long been a field involving a multidisciplinary group of practitioners and researchers. Such a wide variety of disciplines have impacted the ability to find a common language to talk about it. Experts in the mental health field have struggled to define infant mental health in a way that is both comprehensive and comprehensible. In an effort to push the field toward a common understanding of infant mental health, ZERO TO THREE, the National Center for Infants, Toddlers and Families, organized the ZERO TO THREE Infant Mental Health Task Force, consisting of a multidisciplinary group of mental health professionals. The task force developed the following definition that attempts to convey the impact of important variables (relationships, the unfolding growth and development of the child, and the environmental and cultural context in which the child lives) on the emerging social and emotional development of the child.

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.³

Guiding Principles for Quality EHS Program Services

EHS and MSHS program staff and administrators often grapple with how to deliver quality services that best meet the mental health needs of the young children in their programs. Programs can impact the mental health of young children by delivering services that **promote** mental health, **prevent** mental illness, and support families to identify mental health needs and engage in **treatment** when needed. EHS programs do not provide mental health treatment, but they can provide referrals to community providers who do. What many programs don't often realize is that if they are adhering to the Head Start Program Performance Standards, chances are they are already providing a level of quality infant mental health services. For example⁴:

- If program staff provide unhurried time for children to play or explore their surroundings, maintain regular and consistent caregiving routines, maintain low caregiver to child ratios, and offer nutritious meals and opportunities for rest, then programs are engaging in activities that *promote* the mental health of children.
- If programs offer parents opportunities to increase their literacy and job skills, support families to access needed assistance such as housing or immigration services, provide quality child care for working parents, and nurture positive relationships between parent and child, then programs are engaging in activities that help to *prevent* mental illness.
- If programs have strong partnerships with treatment providers in the community, define clear boundaries for staff about their role related to mental health treatment, and provide training opportunities for staff and families to recognize when there may be a mental health concern, then programs are engaging in activities that help to support families to identify and seek *treatment* when needed.

Though many programs are already providing some mental health services, there is still a need to enhance their capacity further. The following guiding principles⁵ are research-based, best practice

³ ZERO TO THREE Infant Mental Health Task Force, 2001.

⁴ Early Head Start National Resource Center, 2003.

⁵ Excerpted from: **Pathways to Prevention: A Comprehensive Guide for Supporting Infant and Toddler Mental Health.** DHHS/ACYF/HSB. 2004.

principles, meant to provide a framework for programs to strengthen the capacity to support the mental health needs of very young children:

- Observe infant-toddler interactions in multiple settings to identify strengths and potential next steps.
- Keep in mind the multiple, potentially interactive origins of an infant's or toddler's behavior, namely, biology (including temperament), developmental stage, environment, and goodness of fit between the baby and his or her family and the child-care setting.
- Identify and share observations of strengths in the infants' and toddlers' relationships with their parents and teachers.
- Listen to parents.
- Listen to staff members.
- Provide regular supervision that allows staff members to reflect on their observations and feelings.

Questions to Consider for Planning and Programming:

- What kinds of promotion and prevention activities does the program engage in with families?
- How does the program build trusting and respectful relationships between staff and parents?
- How does the program support families in building responsive and nurturing relationships with their children?
- How do program staff build responsive and nurturing relationships with children?
- Is the program using multiple observations and ongoing community assessment to learn more about children and families?
- Does the program screen parents for depression?
- How does the program provide supports to children whose parents suffer from mental illness?
- Does the program have a system for referring children and parents for treatment?
- Does the program have partnerships with treatment providers? And how are they defined?
- How does the program support families during and after treatment?
- What are the opportunities for staff and parents to learn about mental health?
- How does the program integrate a reflective supervisory process into the overall program design?
- How does the program access its mental health consultant on a regular basis? Is this consultant experienced in infant/toddler development and understand the importance of relationships in shaping overall development?

Additional Considerations about Maternal Depression

The EHS National Research and Evaluation project⁶ found significant evidence of **depression** among mothers and fathers of children enrolled in the program. Parental depression - particularly maternal depression - is a critical issue for EHS programs, and important to address when considering the mental health needs of young children and families. It is also important to recognize that not all parents experiencing depression are unable to parent effectively. However parental depression does increase the child's risk of abuse and/or neglect, and can compromise the primary relationships that are so critical to a child's well being. The following vignette describes a situation that is not uncommon in EHS families.

Sara is three weeks old. Her mother and father just moved to a new town for dad's new job. They have no families or friends in the area. Dad works long hours and was only able to take a few days off after the baby was born. Mom is by herself all day with Sara. Mom begins to show signs

⁶ DHHS/ACF/OPRE, 2003.

of depression – she’s weepy and listless, and has been spending extended periods of sitting on the couch staring at the TV or out the window. Sara, lying in her crib, is feeling hungry. Her tummy rumbles. She begins to cry. Mom is sitting on the couch with the TV on. She hears Sara’s cries from the other room. Mom sighs and turns up the TV to block out Sara’s cries. Mom begins to cry too. After about 15 minutes, Mom gets up to feed Sara. She brings the baby to the couch to feed her a bottle. Mom looks at Sara’s face. When the baby does not look back at her, Mom sighs again, her body slumps a little, and she looks at the TV for the rest of the feeding.

This example is meant to illustrate one possible way in which maternal depression might manifest itself with a mother and child. It is clear in this situation that the parent/child relationship is vulnerable. Fortunately, EHS programs that approach infant mental health from a promotion, prevention, and treatment perspective can have a positive impact on families such as this. By creating a supportive relationship with the family through consistent and predictable interactions, EHS staff can help to focus on enhancing, supporting and nurturing the parent/child relationship, while addressing the need to seek treatment for the mother. The following are additional examples of how an EHS home visitor might support a family in this situation:

- Build a rapport of trust and empathy and acknowledge the mother’s feelings
- Engage the mother in a postpartum depression screening, ruling out additional concerns such as suicidal or homicidal feelings
- Provide information and support during daily interactions such as feeding, bathing, diapering and help the mother to recognize her strengths
- Support the mother to recognize the moments when she and the baby connect and build on those moments (taking advantage of “teachable moments”)
- Observe the baby in multiple settings with multiple caregivers for a fuller picture of the baby’s overall development
- Engage the mother in a developmental assessment of the baby to help the mother have a better sense of her child’s developmental level and capacity
- Schedule a home visit during a time when the father is available (after work hours or weekends)
- Help the parents to acknowledge the mother’s depression and discuss the benefits of seeing a mental health professional for further assessment
- Work with the program’s mental health consultant to arrange a home visit with the mother for further assessment
- Help the mother to locate possible community resources for respite, postpartum depression groups, new mothers support groups, etc.
- Increase the parent’s social circle by involving them in the socialization groups
- Discuss the family’s situation in reflective supervision for additional support

This is not an exhaustive list of strategies. EHS programs engage families in many other creative and successful ways to address parental depression. The central factor for successfully engaging families in these programs is the relationship between the staff and the family. It is through the creation of nurturing, caring relationships that EHS program staff begin the process of reaching out to families and providing supports that help parents recognize and meet their children’s developmental needs, identify their own mental health needs, and seek treatment.

Performance Standards, Title 45, Code of Federal Regulations:

- 1304.20(b)(1) In collaboration with each child’s parent, and within 45 calendar days of the child’s entry into the program, 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.
- 1304.20(b)(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.
- 1304.20(b)(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.
- 1304.20(d) ...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.
- 1304.20(f)(1) Grantee and delegate agencies must use the information from the screenings for developmental, sensory, and behavioral concerns, the ongoing observations, medical and dental evaluations and treatments, and insights from the child’s parents to help staff and parents determine how the program can best respond to each child’s individual characteristics, strengths and needs.
- 1304.21(a)(3)(i)(A)-(E) Grantee and delegate agencies must support social and emotional development by encouraging development which enhances each child's strengths by:
 - (A) Building trust;
 - (B) Fostering independence;
 - (C) Encouraging self-control by setting clear, consistent limits, and having realistic expectations;
 - (D) Encouraging respect for the feelings and rights of others; and
 - (E) Supporting and respecting the home language, culture and family composition of each child in ways that support the child's health and well being.
- 1304.21(b)(1)(i)-(iii) Child development and education approach for infants and toddlers must incorporate:
 - (i) The development of secure relationships in out-of-home care settings by having limited number of consistent teachers over an extended period of time;
 - (ii) Trust and emotional security so that each child can explore the environment according to his or her developmental level; and
 - (iii) 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)-(ii) Grantee and delegate agencies must support the social and emotional development of infants and toddlers by promoting environments that:
 - (i) Encourages the development of self-awareness, and self-expression; and
 - (ii) Supports the emerging communication skills in daily opportunities for infants and toddlers to interact with others and to express himself or herself freely.
- 1304.24(a)(1)(i)-(vi) 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 behaviors;
 - (iv) Discussing how to strengthen nurturing, supportive environments and relationships in the home and at the program;
 - (v) Helping parents to better understand mental health issues; and
 - (vi) Supporting parents' participation in any needed mental health interventions.
- 1304.24(a)(2) Grantee and delegate agencies must secure the services of mental health professionals on a schedule of sufficient frequency to enable the timely and effective identification of and intervention in family and staff concerns about a child's mental health.
 - 1304.24(a)(3)(i)-(iv) 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 help for children with atypical behavior or development; and
 - (iv) Utilize other community mental health resources as needed.
 - 1304.40(c)(1)(iii) Early Head Start grantee and delegate agencies must assist pregnant women to access comprehensive prenatal and postpartum care, through referrals, immediately after enrollment in the program. This care must include mental health interventions and follow-up, including substance abuse prevention and treatment services, as needed.
 - 1304.40(c)(2) Grantee and delegate agencies must provide pregnant women and other family members, as appropriate, with prenatal education on fetal development (including risks from smoking and alcohol), labor and delivery, and post-partum recovery (including maternal depression).
 - 1304.40(f)(1) Grantees and delegate agencies must provide medical, dental, nutrition, and mental health education programs for programs staff, parents, and families.
 - 1304.40(f)(4)(i)-(iii) Grantee and delegate agencies must ensure that the mental health education program 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; and
 - (iii) The active involvement of parents in planning and implementing any mental health interventions for their children.
 - 1304.52(d)(4) Mental health services must be supported by staff or consultants who are licensed or certified mental health professionals with experience & expertise in serving young children & families.

Resources:

A Commitment to Supporting the Mental Health of our Youngest Children: Report of the Infant Mental Health Forum. DHHS/ACF/ACYF/Commissioner's Office for Research and Evaluation (CORE) and HSB. October 2000.

http://www.acf.hhs.gov/programs/opre/ehs/mental_health/reports/imh_report/imh_rpt.pdf
(accessed August 14, 2010).

Early Head Start National Resource Center. **EHS Program Strategies: Responding to the Mental Health Needs of Infants, Toddlers and Families.** DHHS/ACF/ACYF/HSB. 2003.

Early Head Start National Resource Center. **Pathways to Prevention: A Comprehensive Guide for Supporting Infant and Toddler Mental Health.** DHHS/ACYF/HSB. 2004.

Early Head Start Research and Evaluation Project. **Research to Practice Brief: Depression in the Lives of Early Head Start Families.** DHHS/ACF/OPRE. April 2006.

http://www.acf.hhs.gov/programs/opre/ehs/ehs_resrch/reports/dissemination/research_briefs/research_brief_depression.pdf (accessed August 14, 2010).

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Mann, Tammy L. "Promoting the Mental Health of Infants and Toddlers in Early Head Start: Responsibilities, Partnerships, and Supports." *Zero To Three Journal* 18(2). (Oct/Nov 1997): 37–40.

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<http://eclkc.ohs.acf.hhs.gov/hslc/ecdh/Mental%20Health> (accessed August 14, 2010).

National Research Council and Institute of Medicine. **From Neurons to Neighborhoods: The Science of Early Childhood Development.** Washington, DC: National Academy Press. 2000.

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Shirilla, J.J. and Deborah J. Weatherston, Eds. **Case Studies in Infant Mental Health: Risk, Resiliency, and Relationship.** Washington, DC: ZERO TO THREE. 2002.

Zero To Three Journal, 22(1): Infant Mental Health and Early Head Start: Lessons for Early Childhood Programs. (Aug/Sept. 2001).

Zero To Three Journal, 18(2): Perinatal Mental Health: Supporting New Families through Vulnerability and Change. (Jun/July 2002).

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This Tip Sheet is not a regulatory document. Its intent is to provide a basis for dialogue, clarification, and problem solving among Office of Head Start, Regional Offices, TA consultants, and grantees. If you need further clarification on Head Start Policies and regulations, please contact your Regional Program Specialist.