BRIGHT FUTURES

Promoting Child Development and Mental Health - (Part 1)

January 26, 2011

Introduction to Media Site

Ann Stueck, Infant and Child Nurse Consultant
Bureau of Community Health Promotion (BCHP)
Family Health Section (FHS)
Before We Get Started

http://dhs.wisconsin.gov/dph_bfch/MCH/BrightFutures.htm

Remember to complete the evaluation when we are finished.

It can be found on the above website, along with the slides from today’s presentation.

If more than one person is at your site, please send one email informing us of how many.

Evaluation for the Early Childhood System Participants


Please complete both evaluations by February 9th!
ASK A QUESTION !!

by using feature at top of speaker screen
anytime during the presentations

PRESENTERS

Murray L. Katcher, Chief Medical Officer, BCHP
Wisconsin Department of Health Services (DHS)

Therese Ahlers MS, MPA, Executive Director
WI Alliance for Infant Mental Health
Integrating Bright Futures into Public Health at the State and Local Levels

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Wisconsin Department of Health Services (DHS)
What Is Bright Futures?

Bright Futures is a national health care promotion and disease prevention initiative that uses a developmentally-based approach to address children’s health needs in the context of family and community.
Integrating Bright Futures into Public Health at the State and Local Levels

Bright Futures Guidelines—3rd Edition

Features of special interest to Public Health professionals:

- Revised Periodicity Schedule
- Integrated adaptations throughout for children and youth with special health care needs
- Visit section defines newer, more family- and community-driven, enhanced content for the well care of infants, children, and adolescents in primary care practice
- The 10 Themes have special application to Public Health
Integrating Bright Futures into Public Health at the State and Local Levels

How do the 3rd edition Guidelines differ from previous editions?

• **Structure**
  - Part I—Themes
    - Includes 10 chapters highlighting key health promotion themes
    - Emphasizes “significant challenges”—e.g., mental health and healthy weight
  - Part II—Visits
    - Provides detailed health supervision guidance and anticipatory guidance for 31 age-specific visits
    - Lists 5 priorities for each visit
    - Includes sample questions and discussion topics for parent and child

• **Health Supervision Priorities**
  - Designed to focus visit on most important issues for age of child
  - Anticipatory guidance presented in several ways
  - Include health risks, developmental issues, positive reinforcement
Wisconsin’s Bright Futures Webcasts
http://dhs.wisconsin.gov/dph_bfch/MCH/BrightFutures.htm

Applying the 10 Bright Futures Themes to Public Health

- Promoting Oral Health
- Promoting Safety and Injury (and Violence) Prevention
- Promoting Healthy Weight
- Promoting Healthy Nutrition
- Promoting Physical Activity

Wisconsin’s Bright Futures Webcasts

Applying the 10 Bright Futures Themes to Public Health

- Promoting Family Support
- Promoting Child Development
- Promoting Mental Health
- Promoting Healthy Sexual Development and Sexuality
- Promoting Community Relations and Resources
Child Development and Infant Mental Health

Reference: Institute of Medicine Study (2000)

Jack Shonkoff and Deborah A. Phillips, eds

From Neurons to Neighborhoods: The Science of Early Childhood Development

http://books.nap.edu/catalog.php?record_id=9824
INFANT MENTAL HEALTH

Therese Ahlers MS, MPA,
Executive Director
WI Alliance for Infant Mental Health

What is Infant Mental Health and What it is Not

How is Infant Mental Health Developed?

Why Care About Infant Mental Health?
Infant and Early Childhood Mental Health

The developing capacity of the child from birth to five 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

Adapted from a working definition developed by Zero to Three: National Center for Infants, Toddlers and Families—Infant Mental Health Task Force

What Infant Mental Health is NOT:

It all started in my childhood
Synonymous with healthy social and emotional development

Curiosity
Persistence
Trust
Self confidence
Motivation

Healthy Social and Emotional Development: What is it?

• A sense of confidence and competence
• Ability to develop good relationships with peers and adults/make friends/get along with others
• Ability to persist at tasks
• Ability to follow directions
• Ability to identify, understand, and communicate own feelings/emotions
• Ability to constructively manage strong emotions
“THERE IS NO SUCH THING AS A BABY
THERE IS A BABY AND SOMEONE”
D.W. Winnicott

How developed?

Relationships with parents and other caregivers

– Fostered through nurturing, responsive and supportive relationships

– The child learns that she has an impact on her environment
The first three years of a child’s life are critically important to brain development

**Plasticity:** the capacity of the brain to be affected by experiences

700 new neural connections form *every second* in the first three years of life

**Domains of development interrelated**

- Cognitive
- Language
- Social
- Emotional
- Physical

Closely intertwined and dependent on early experiences and relationships
Why Care About Infant Mental Health?

- Babies can’t wait
  - Early years offer a critical window of opportunity –born wired to feel and learn

- Science supports
  - Babies more vulnerable than older children to emotional and social deprivation

- Social and emotional development is firmly tied to all other areas of development
  - Cognitive, language, memory, physical

_Neurons to Neighborhoods: The Science of Early Childhood Development_

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Why Care About Infant Mental Health?

- Economic benefits of healthy social and emotional development
  - Public investment in early years show a huge payoff

- Social and emotional development linked to success in school and beyond
  - Poor social and emotional development predict early school failure

- Protective factor against child abuse and neglect
  - Center for the Study of Social Policy
If a child doesn’t know how to read, we teach.
If a child doesn’t know how to swim, we teach.
If a child doesn’t know how to multiply, we teach.
If a child doesn’t know how to drive, we teach.
If a child doesn’t know how to behave, we …?

Why can’t we finish the last sentence as automatically as we do the others?

Tom Herner (NASDE President) Counterpoint 1998, p.2
The Importance of Early Parent-Child Relationships:
Secure Attachment Relationships and the Promotion of Emotion, Behavior and Attention Regulation

The Influence of Parent’s Mental Health on the Child's Development: Maternal Depression

Intervention approaches for supporting Healthy Parent-Child Relationships:
Special Play

Basic Tenets For a Relational Approach in Infant Mental Health

• The infant's relationships form the cornerstone of their development
• The relationship of an infant and caregiver is the unifying environmental context
• The caregiver is the central organizing agent for the child
• Practitioners value and respect the context of the infant-caregiver relationship
• Relationships are valued as central to all assessment & intervention
• The interaction reflects the life experiences and capacities of both the infant and the parent

-Adapted from AZ Dept. of Health Services (1998)
There is no such thing as a baby

Winnicott (1965)

The Importance of Parenting for Infant and Early Childhood Development

Why do early relationships matter in social and emotional Development?
Biological Evidence for the Importance of Early Relationships

- There is growing biological evidence that infants need sensitive, responsive care in order for the parts of their brain that regulate the experience and expression of emotions to develop.
- The brain operates on a “use it or lose it” principle as it develops: only those pathways that are frequently activated are retained.
- When the caregiver effectively manages the infant’s emotional states, the baby develops the neurological, endocrine and emotional foundations that allow them to gradually learn to regulate their emotions on their own.

History of Being Parented

- “Ghosts” & “Angels” in the nursery
  (Fraiberg et al., 1980; Lieberman, 2007)

- Representations of history of being parented
  - Adult Attachment Interview (George et al, 1996):
    - Secure, pre-occupied, dismissive
Attachment Patterns

Secure attachment

**Parent:** Is sensitive, responsive, and available
**Child:** Feels valued and worthwhile; has a secure base; feels effective; feels able to explore and master, knowing that parent is available and supports autonomous strivings.

Attachment Patterns

Insecure and avoidant attachment

**Parent:** Is insensitive to child's cues, avoids contact, and rejects

**Child:** Feels no one is there for him; cannot rely on adults to get needs met; feels he will be rejected if needs for attachment and closeness are shown and, therefore, asks for little to maintain some connection; and learns not to recognize his own need for closeness and connectedness.
Attachment Patterns

*Insecure attachment characterized by ambivalence and resistance*

**Parent:** Shows inconsistent patterns of care; is unpredictable; may be excessively close or intrusive and then push away; and seen frequently with depressed caregiver.

**Child:** Feels he should keep adult engaged because he never knows when he will get attention back; anxious; dependent; and clingy.

Bright Futures, AAP

Assessing Strengths and Areas of Concern in Early Parent-Child Relationships

**Parental positive affective involvement, sensitivity, & responsiveness**

**Parental negative affect and behavior**

**Parental insensitivity, inconsistency and anxiety**
Assessing strengths and areas of concern

Infant Positive Affect, Communicative and Social Skills

Infant Quality of Play, Interest and Attentional Skills

Infant Dysregulation and Irritability

Assessing Strengths and areas of concern

Dyadic Mutuality and Reciprocity

Dyadic tension
### Goals of Emotional Development

<table>
<thead>
<tr>
<th>Goals of Emotional Development</th>
<th>How Early Relationships Can Support Healthy Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeostasis and Regulation</td>
<td>Awareness of child’s sensory thresholds and needs. Provision of predictable, responsive care.</td>
</tr>
<tr>
<td>Attachment</td>
<td>Capture child’s alert states for pleasurable and joyful face-to-face interactions.</td>
</tr>
<tr>
<td>Two-way Communicating</td>
<td>Exchange animated facial expressions, sounds and gestures. Help child open and close circles of communication.</td>
</tr>
<tr>
<td>Problem-Solving and Self-Discovery</td>
<td>Utilize floor-time for joint attention and scaffolding to encourage problem-solving. Help child clarify intentions with language.</td>
</tr>
</tbody>
</table>

(Greenspan, 1999)

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**Early caregiver sensitivity, responsiveness and consistency are crucial for healthy infant/child emotion, behavior and attention regulation**
The Importance of the Development of Self-Regulation

Children with inadequate self-control can be impulsive or hyperactive, heightening concerns for safety. At the opposite extreme, children with excessive self-control tend to be anxious or have fixed behaviors. Of course, behavior varies so that a child may exhibit a great variety of behaviors at any given time in response to the same external cues.

Mastering activities in daily life shows that the child is moving toward achieving self control.

Chief among these are learning how to calm herself (which is needed to establish a regular sleep pattern), feed herself, toilet train, and take the major step of attending school.

Health care professionals should actively prepare parents and their toddlers for achieving these milestones through discussing these topics and, when concerns persist after counseling, make referrals for appropriate consultation.

Bright Futures, AAP

Early Relationships and Emotion Regulation

- Infancy is a period of relative dependence on adult regulation
- Episodes of emotion dysregulation are typically managed by caregivers - promoting a sense of well-being and minimizing experience of stress and danger

Cole, Michel & Teti, 1994
Early Relationships & Emotion Regulation

- Facilitates periods of sustained attention so infant/child is available for interaction and learning, including exchanges of positive emotion

- Provides basis for secure attachment response

Cole et al., 1994; Kuff & Rothbart, 1996; Winnicott, 1965

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Early Relationships and Emotion Regulation

- Experience of positive emotion helps infants to organize their experience

- Infant-caregiver relationships provides the context for the socialization of emotion regulation - particularly in the context of face-to-face interactions

Cole, Michel & Teti, 1994
Early Relationships and Emotion Regulation

- Infants as young as 7 months old reference the emotional expressions of caregivers before determining their emotional state and behavior.

- Longitudinal studies have demonstrated a relationship between early maternal contingent responsivity and emotional synchrony and subsequent development of social and cognitive skills related to emotion regulation.

Emotion Regulation Cycle

Infant Signal (e.g., cry)
↓
Caregiver’s Emotional Arousal Stimulated
↓
Caregiver Manages own Emotion to Remain Available
↓
Caregiver Responds (e.g., soothe)
↓
Infant experiences regulation

- Adapted from J. Dean (1999)
Encouraging Emotion Regulation

• “The emphasis in describing different attachment classifications, at least partly, in terms of how a parent and child manage emotions and in linking this to different behavioral and neurobiological reactions has lead to some researchers to describing attachment theory as primarily a theory of emotion regulation.” (Cassidy, 1994; Hofer, 2006; Laible & Thompson, 1998; Schore, 2001, 2003).

• During infancy, emotion regulation depends on caregiver support and caring responsiveness
  – During caring and attuned interactions, the parent’s emotional containment is absorbed by the infant, which enables the infant to gradually be able to regulate and organize his own states
  – “When a mother is less engaged and sensitive to her infant in the first year, the child will show more signs of anxiety during her third year.” (Crockenberg, 2006).
  – “Securely attached children who have been responded to consistently are able to accept and understand positive and negative affects, whereas insecurely attached children frequently exhibit limited or heightened negative affect and have difficulty in modulating emotions.” (Calkins & Hill, 2007; Cassidy, 1994; Laible & Thompson, 1998; Sroufe, 2000)
  – “If parents are dismissive of their children’s emotions, criticize them for having them, or become overwhelmed themselves, the lack of containment results in children being unable to manage their emotions.” (Berlin & Cassidy, 2003; Denham et al., 2007; Eisenberg et. al., 2001).
  – “Certain characteristics of mothers have been found to relate to emotion dysregulation in children including past experience of trauma, that was related to parenting that is very dysregulated.” (Katz & Maytal, 2005; Koren-Karie, Oppenheim, & Getzler-Yosef, 2004).
  – If mothers are unable due to depression, to modulate environmental stimuli for their infants, the infant becomes a reaction to impingements from the environment or anxious. (Landy, 2009)

Early Relationships and Attention Regulation

• Caregivers’ modulation of arousal for the infant helps him focus and sustain attention to interactions with both objects and people

• When an infant is over-stimulated or over-reactive to stimuli, she may withdraw and lose opportunities for interaction and learning

• If mothers are unable due to depression, to modulate environmental stimuli for their infants, the infant becomes a reaction to impingements from the environment or anxious.

(Winnicott, 1965; Ruff & Rothbart, 1996)
Behavior Regulation

Beyond nurturance, love and a sense of security and well-being, children need consistency, clear limits and behavioral guidance to be able to learn to regulate their behavior. General features of effective behavioral guidance include several essential components, all of which are necessary for successful discipline:

A positive, supportive, loving relationship between the parents and child (children want to please their parents)

Clear expectations communicated to the child in a developmentally appropriate manner

Positive reinforcement strategies to increase desired behaviors (eg, having fun with the child and other family members sets the stage to reward and reinforce good behaviors with time together in enjoyable activities)

Removal of reinforcements or use of logical consequences to reduce or eliminate undesired behaviors

Parents can increase the likelihood of achieving their behavioral goals for their child by establishing predictable daily routines and providing consistent responses to their child’s behavior. Especially during early childhood,

Consequences should be administered within close temporal proximity to the target behavior and, if possible, related to the behavior

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Parents can use the following techniques to help foster positive behavior in their child:

- Praise the child frequently for good behavior. Specific acknowledgement (rather than global praise) helps teach the child appropriate behaviors (eg, “Wow, you did a good job putting that toy away!” rather than “Great!”). Time spent together in an enjoyable activity is a valuable reward for desired behavior.

- Communicate expectations in positive terms. By noting when the child is doing something good, parents will help the child understand what they like and expect. Words such as, “I like it when you play quietly with your brother,” or “I like that you climb into your car seat when I ask you to,” are nonjudgmental statements and communicate to the child that these are behaviors the parents like.

- Model and role-play the desired behaviors.

- Prepare the child for change in the daily routine by discussing upcoming activities and expected behaviors.

- State behavioral expectations and limits for the child clearly and in a developmentally appropriate manner. These expectations should be few, realistic, and consistently enforced.

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Bright Futures, AAP
Behavior Regulation

Key Messages for Parents:

- **Discipline means teaching, not punishing.**
- All children need guidance, and most children need occasional discipline.
- Discipline is effective when it is consistent; it is ineffective when it is not consistent.
- Parents’ discipline should be geared to the child’s developmental level.
- Discipline is most effective when the parent can understand the child’s point of view.
- Discipline should help a child learn from his mistakes. The child should understand why he is being disciplined.
- Disciplinary methods should not cause a child to feel afraid of his parents.

Challenges to the Development of Mental Health

*Signs of possible problems in emotional well-being in infants include the following:*

- Poor eye contact
- Lack of brightening on seeing parent
- Lack of smiling with parent or other engaging adult
- Lack of vocalizations
- Not quieting with parent’s voice
- Not turning to sound of parent’s voice
- Extremely low activity level or tone
**Signs of possible problems in emotional well-being in infants cont.:**

- Lack of mouthing to explore objects
- Excessive irritability with difficulty in calming
- Sad or somber facial expression (evident by 3 months of age)
- Wariness (evident by 4 months of age; precursor to fear, which is evident by 9 months of age)
- Dysregulation in sleep
- Physical dysregulation (e.g., vomiting or diarrhea)
- Poor weight gain

**Bright Futures, AAP**

**Signs of possible problems in emotional well-being in young children:**

- Regulatory difficulties in sleeping, feeding or behavior
- Irritable, serious or depressed mood
- Aggressive, disruptive or hyperactive behavior
- Avoidant or withdrawn behavior
- Excessive fears or anxieties
- Hypersensitivity to touch or sound
- Disorders of communication or relatedness
- Developmental delays
Relationships at-Risk

Effects of depression on maternal functioning and mother-infant and family relationships
Depression and its effects on Maternal Functioning

- Impaired ability to be involved in child’s physical care and play
- Irritability and self-preoccupation—inaibility to meet child’s normal needs for attention
- Lack of affection towards child and resulting feelings of guilt and inadequacy
- Anxiety about doing psychological or physical harm towards child
- Feeling confused about how they could feel this way with a new baby

Weissman et al., 1979

Mother-Infant Interaction Quality

- In the still face paradigm, infants of depressed mothers showed less interest, more anger and sadness and a greater tendency to fuss than infants of non-depressed infants. These findings suggest that infants of depressed mothers have difficulty regulating emotions and repairing interactions after a disruption.

- Depressed mothers perceived interactions with their infants more negatively, and showed more anger in interactions with their infants than non-depressed mothers.

Weinberg & Tronick, 1998
Mother-Infant/Child Attachment

- Severity of maternal depression symptoms related to quality of mother-infant attachment
- Disorganized-disoriented attachments 3-4 times more likely in children whose mothers were depressed compared to children whose mothers were not depressed
- Interventions focused on increasing maternal sensitivity are effective in enhancing maternal sensitivity and infant attachment, regardless of risk characteristics


Bi-Directional Effects in Depressed Mother-Infant Interactions

Mother’s depressed mood may induce a depressed state in the infant

Field 1997
Bi-Directional Effects in Depressed Mother-Infant Interactions

- Infant’s subsequent distress and unresponsiveness are likely to maintain and perhaps increase the severity of the mother’s depression.

- Lack of infant responsiveness may validate the mother’s depressive self-schemata and her experience of herself in relationships.

Consequences of maternal depression for infant/child development and problems in regulation.
Infants of Postpartum Depressed Mothers: Behavioral Observations

- More negative affect both with mother AND other non-depressed adults
  - More sober, sad and/or flat affect
  - More protest behaviors
- Regulation difficulties
- More gaze aversion; less eye contact
- Fewer vocalizations; delayed language development
- Lower activity level
- Limited exploration of the environment

Clark et al., 1994; Field, 1995

Physiologic and Behavioral Correlates of Infants of Depressed Mothers

- Less orienting behavior
- More depressed behavior
- More stressed behaviors
- More indeterminant sleep
- Right frontal EEG activation
- Lower Vagal tone
- Higher norepinephrine levels
- Higher cortisol levels

⇒ Profile of dysregulation

Field, 1997
**Effects of ↑ HPA System Activity on The Developing Brain**

- Ongoing elevated cortisol interferes with memory, learning, attention and behavioral regulation

- ↑ Elevated cortisol levels ⇒ contributes to the hyper-responsive infant by lowering the threshold for experience of negative emotions (fear and anger) and for activation of stress systems

  Gunnar, 1998

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**Mechanisms by which Maternal Depression May Effect Infant/Child Development**

- Exposure to symptoms
- Alterations in parenting
- Changes in family structure or functioning
- Genetic Factors
- Interaction of genetic and environmental factors
- Depression is incidental but correlated factors are influential
- Interaction of depression and correlated factors

  Cox et al., 1987
Risk and Protective Factors Moderating Infant/Child Outcome

- Mothers’ personality and history of relationships
- Father’s involvement with the child
- Infant/Child Temperament
- Infant/Child Gender
  - Mothers show more anger toward their sons and sons shows less positive affect and have greater difficulty regulating their emotions

(Rothbart, 1998)

Risk and Protective Factors Moderating Infant/Child Outcome

- Length of Parental Leave
  - Mothers who returned to work earlier expressed more negative affect and behavior in interacting with their infants.

  - Mothers who reported more depressive symptoms or perceived their infants as having a more difficult temperament and had shorter leaves, compared with mothers who had longer leaves were observed to express less positive affect, sensitivity, and responsiveness with their infants.

Clark, Hyde, Essex, & Klein, 1997
Maternal Depression and Child Development


- Women with chronic depressive symptoms were the least sensitive when observed playing with their children from infancy through 36 months.

- Children of mothers who reported feeling depressed performed more poorly on measures of cognitive-linguistic functioning, cooperation and behavior problems at 36 months.


Theoretical model of the relationship between maternal depression and child behavioral outcome.

Mother's Observed Behavior

Maternal Depression

Marital Conflict

Child Behavior Problems

Contextual Risk Factors
The Importance of Play

Play is a critical part of development, and toys are a critical part of play. Health care professionals often are asked to recommend appropriate toys by parents. Toys should be educational and should promote creativity.

Parents and health care professionals should avoid toys that make loud or shrill noises, toys with small parts, loose strings, cords, rope, or sharp edges, and toys that contain potentially toxic materials. Toys that promote violence, social distinctions, gender stereotypes, or racial bias also should be avoided.

Video games are not recommended for young children, but, if used, they should be screened for inappropriate content.

Health care professionals should advise parents on distinguishing between safe and unsafe toys, choosing toys that help promote symbolic play, emotional expression and learning, and using books and magazines to read and play together.

Play provides a window into many aspects of the child’s developmental progress and into how she is attempting to understand and master the events, transitions, and stresses of everyday life.

Parents and other caregivers should recognize the importance of play for the development of their young children.

Play requires that children feel secure and that the play environment be sufficiently protected from intrusion and disruption.

Parent-child play, in which the child takes the lead and the parent is attentive and responsive, elaborating but not controlling the events of play, is an excellent technique for enhancing the parent-child relationship and language development.

Adapted from Bright Futures, AAP

Special Play

![Image of a caregiver and a child playing together, with various toys around them.]
Special Play

Before you start:

• Are you ready?
  Rested, smiling, interested
  Set aside 10-15 minutes, non-distracted 1:1 time

• Is your child ready?
  Rested, good mood, alert, comfortable
  – Is the Special Play area ready?
  Clean, safe, ready for the child to explore

Starting Special Play

• Tell you child “It’s time for Special Play”

• Help your child select two to four toys and take them to the Special Play area.

• Sit near your child and let your child begin to play.
During Special Play:

• Stay near your child
  Follow if they move

• Let your child decide what to do
  Follow their lead
  When invited join their play

• Stay positive
  Give lots of “yes’s”
  Bright, positive facial expressions and tone of voice
  Provide encouragement

During Special Play

• Let your child know you are interested
  – Look at him, touch smile and laugh
  – Watch and wonder at what they do!
  – Imitate
  – Acknowledge your child’s feelings and desires

• Talk with your child
  – Describe what he or she is doing...Be a “Sportscaster”
  – Answer when they ask questions
During Special Play Avoid

• Teaching
• Asking Questions
• Correcting
• Directing

Ending Special Play

• Say “It’s time to stop Special Play. I had fun playing with you!”
• If you want, say “Let’s pick up the toys now”.
• Remind your child when you will have Special Play again.
Rewards of Special Play

- Reduction of anxiety
- Reduction of aggressive and acting out behavior
- Increase in compliance in the child
- Increase in a sense of competence in the parent
- Increase in mutually enjoyable times for parent and child together
- Development of trust and a sense of well-being in the relationship for both the child and the parent
Integrating Bright Futures into Public Health at the State and Local Levels

Child Development and Screening

“Bright Futures is a national health care promotion and disease prevention initiative that uses a developmentally-based approach to address children’s health needs in the context of family and community."

- Promoting Development
- Benefits of developmental screening
- Selecting a screening tool
- Ages and Stages Questionnaires in Wisconsin
- So what?
- Resources

Bright Futures Promotes Child Development in all Domains

Language | Intellectual
Social-emotional | Motor
Benefits of a Screening Process

- Detects a child’s strengths and needs
- Educates parents
- Builds partnerships with parents
- Opens conversations about concerns
- Identifies children at risk of developmental delays
- Provides a first step in planning for intervention
- Improves health and developmental outcomes through early intervention.

Selecting a Screening Tool

- Is it valid?
- Is it reliable?
- Is it a normed tool?
- Is it culturally sensitive?
- Is it comprehensive?
- Is it attractive to children and parents?
- Is it affordable?
- What training is recommended?
Ages and Stages Questionnaires in WI

- Rated positively
- Recommended by AAP
- Over 800 home visitors trained in this tool since 2003
- Well-supported by authors
- Well-supported by SPHERE
- Selected by Project LAUNCH
- Supported by Wisconsin Early Childhood Collaborating Partners

So What?

“A developmental screening process helps us keep the promise that no child will enter kindergarten with an undetected delay”
Integrating Bright Futures into Public Health at the State and Local Levels

Resources

- Bright Futures
  http://brightfutures.aap.org/pdfs/Health_Promotion_Information_Sheets/childdevelopment.pdf
- Wisconsin Early Childhood Collaborating Partners
- University of Wisconsin Cooperative Extension
  http://parenting.uwex.edu/
- Regional Centers for Children with Special Health Care Needs

RESOURCES TO SUPPORT PRACTICE

Therese Ahlers MS, MPA, Executive Director
WI Alliance for Infant Mental Health

Linda Tuchman-Ginsberg, PhD
Waisman Center, University Center for Excellence in Developmental Disabilities, UW-Madison

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Integrating Bright Futures into Public Health at the State and Local Levels

RESOURCES TO SUPPORT PRACTICE

Therese Ahlers MS, MPA, Executive Director

Reflective Practice

WI Alliance For Infant Mental Health

Competency And Endorsement System

Reflective Practice

Supportive relationship with a supervisor or consultant exploring the feelings and experiences raised by working with young children and their families over time

Provides a safe place to explore, understand, and distill the negative or difficult emotions elicited from the work with young children and their families

Consistent space to become aware of and attend to feelings to avoid reactive responses that can lead to unintended and negative consequences
Three primary facets of reflective supervision

Reflection: supervisor and supervisee’s ability to explore the feelings, thinking and observations from a number of perspectives

Collaboration non-judgmental exchanges dependent on the complete attention of the provider and supervisor

Regulation: ongoing predictable frequency of meetings to establish emotional safety in order to explore strengths and areas requiring attention and supported growth regarding the complicated work with families of young children

Our Vision
For every infant and young child in Wisconsin to have his or her social and emotional developmental needs met within the context of their family, community and culture.

Our Mission
- Increase knowledge
- Promote collaboration
- Influence public policy
Infant and Early Childhood Mental Health Competency and Endorsement System

Competency: What is it?

“…a set of values, knowledge, and skills that result in a person being able to do the right thing for the right reason at the right time.

Myers, Kaufman & Goldman, 1999 & Myers, 2007

Competency: What is it?

“…the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.”

Epstein & Hundert, 2002
Competencies are multidisciplinary

- Specific educational experiences
- Direct service experiences with infants, toddlers & families
- Specialized in-service training
- Reflective supervision/consultation for levels 2, 3, and 4

Competency and Endorsement Framework

Interdisciplinary professional development system recognizing competency:

- Infant Family Associate - Level I
- Infant Family Specialist - Level II
- Infant Mental Health Specialist – Level III
- Infant Mental Health Mentor Level IV (clinical, policy or faculty/research)
Why are competency based systems for infant and early childhood mental health essential?

• To guide training programs
• To enhance professional credibility
• To provide benchmarks for knowledge and skills
• To enhance accountability in the infant and family field

Korfmacher & Hilado, Herr Research Center

League of States

• In September, 2007 leaders from states who had purchased a license to use the MI-AIMH Competencies and Endorsement formed a “league of affiliate states” to support one another in implementing the standards and agreed to convene annually.
• The leadership from these states also agreed that their affiliates/organizations would recognize Endorsement by any one of the member states, further promoting reciprocity, collaboration and systems change.
League Members

Alaska Association for Infant Mental Health (Competencies only)
Arizona: Infant Toddler Children’s Mental Health Coalition
Connecticut Association for Infant Mental Health
Colorado Association for Infant Mental Health (Competencies only)
Idaho Association for Infant Mental Health
Indiana Association for Infant and Early Childhood Mental Health
Kansas Association for Infant and Early Childhood Mental Health
Minnesota Association for Infant & Early Childhood Mental Health
New Mexico Association for Infant Mental Health
Oklahoma Association for Infant Mental Health
Texas Association for Infant Mental Health
Wisconsin Alliance for Infant Mental Health
Virginia Association for Infant Mental Health

Integrating Bright Futures into Public Health at the State and Local Levels

RESOURCES TO SUPPORT PRACTICE

Linda Tuchman-Ginsberg, PhD
Waisman Center, University Center for Excellence in Developmental Disabilities, UW-Madison

Roseanne Clark, PhD, Associate Professor
Department of Psychiatry
UW School of Medicine and Public Health

Mental Health Certificate
University of Wisconsin, Infant Early Childhood and Family Mental Health Certificate Program

Roseanne Clark, Ph.D  
Linda Tuchman-Ginsberg, Ph.D.
Co-Directors

Sponsoring Partners

- University of Wisconsin
  - Department of Psychiatry, School of Medicine and Public Health
  - Waisman Center
  - Professional Development and Applied Studies
- Wisconsin Alliance for Infant Mental Health
  http://www.dcs.wisc.edu/pda/mental-health/infant.htm
Appreciations for Contributors

- Wisconsin Department of Health Services
  - Birth to 3 Program
  - Public Health (ECCS, Project Launch)
  - Bureau of Prevention, Treatment and Recovery: Substance Abuse Services
- Celebrate Children Foundation
- Wisconsin Department of Children and Families, Home Visiting Program
- Wisconsin Head Start Collaboration Project

Participants

- Fellows in Infant, Early Childhood and Family Mental Health

Certificate Program Pathways:

- Foundations
  - Early Intervention, Child Care and Home Visitation professionals
- Advanced Clinical Practice
  - Mental health and other licensed professionals
Faculty/Staff

- **Co-Directors**
  - Roseanne Clark, PhD, UW Department of Psychiatry
  - Linda Tuchman-Ginsberg, PhD, Waisman Center

- **Coordinator**
  - Ann Whitaker, MS
  - UW Department of Professional Development and Applied Studies

- **Wisconsin Alliance for Infant Mental Health**
  - Therese Ahlers, MS, MPA
  - Janna Hack, LCSW, IMH-E® (IV)
  - Lana Nenide, MS

Program Components

- **Monthly Sessions for 13 months**
  - 2-3 days per month

- **Readings**

- **Assignments**
  - Infant Observation and Reflection
  - Assessment and Intervention Projects and Reports
  - Individual Projects

- **Reflective Mentoring Groups**

- **Clinical Consultation**
**Relationship to Endorsement**

- **Infant Mental Health Endorsement**
  - Wisconsin Alliance for Infant Mental Health
  - Associated with the Michigan Endorsement

- **UW Certificate Program**
  - Helps fellows meet the knowledge base, competencies and reflective practice mentoring and consultation

**Reflective Mentoring Groups**

- Creates time for thoughtful examination

- Involves stepping back from the immediate experience to sort through thoughts and feelings about what your observing and doing with children and families

- Creates a “holding environment” for difficult feelings

- Recognizes the importance of relationships and reciprocity in our work.

*(Fenichel, 1992)*
Reflective Mentoring Groups

- 2 hours per month
  - Mentors facilitate discussion and reflection upon lectures, readings, and Infant Observation experiences
  - Case-based discussions and integration of new learning into Fellows’ current work and practice

Clinical Consultation

- For Advanced Clinical Practice Fellows
- 2 hours per month between sessions
- Case-based reflections and learning
Program Schedule, Content and Faculty

- Based on competencies for the Wisconsin Infant Mental Health Endorsement (WI-AIMH)
- Faculty
  - National expertise
  - State and local expertise
  - Fellows experience and expertise

Framework
An Ecological Model for Assessment and Intervention

Topics

- Promotion of Healthy Social and Emotional Development
- Supporting Early Relationships and Attachment
- Promoting Emotion and Behavior Regulation
- Infant Development and Observation
- Risk and Protective Factors: e.g. Maternal Depression; Substance Abuse; Family and Cultural Values and Support
- Screening and Assessment
- Therapeutic Interventions
- Public Awareness, Policy and Will
Early Experiences Matter: The Importance of Relationships

THANK YOU!

Roseanne Clark, Ph.D.
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University of Wisconsin School of Medicine and Public Health
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Waisman Center, University Center for Excellence in Developmental Disabilities
University of Wisconsin-Madison
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• Time for Questions

~ SAVE THE DATES ~

• **March 22, 2011** - Bright Futures: Promoting Child Development and Mental Health Part 2

• **May 18, 2011** - Bright Futures: Promoting Healthy Sexual Development and Sexuality
TO DO
Complete Bright Futures Webinar Evaluation!!

COMPLETE EVALUATIONS:
http://dhs.wisconsin.gov/dph_bfch/MCH/BrightFutures.htm

• Early Childhood Systems Participants: