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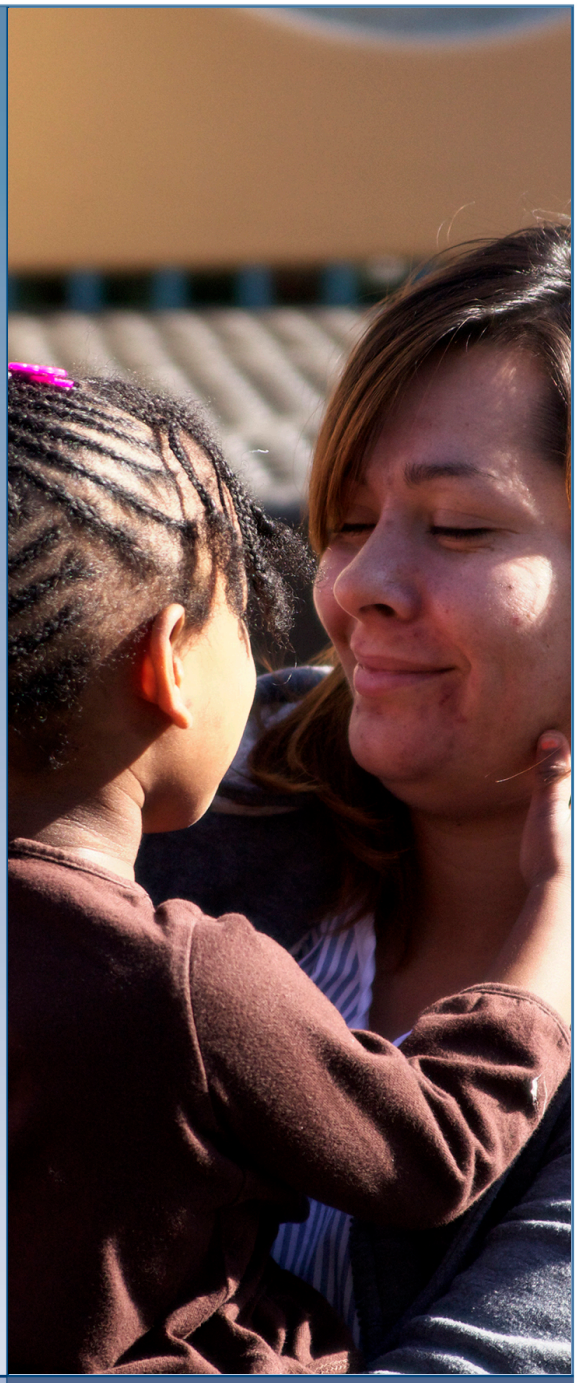
Foundations of Infant-Family and Early Childhood Mental Health Training Program: Year 4



Evaluation report prepared for First 5 Monterey County by WestEd Center for Prevention & Early Intervention

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Table of Contents

Executive Summary

Professionals working with young children require specialized training and reflective practice opportunities in order to best support young children and their families. Recognizing the need to develop ongoing capacity in the field of infant-family and early childhood mental health, the First 5 Monterey County Commission launched a multi-year Foundations of Infant-Family and Early Childhood Mental Health (IFECMH) Training Program. The program is designed to strengthen the capacity of the diverse workforce of partners across systems serving children, prenatal through age 5, and their families, in order to build mental health expertise along the continuum of promotion, preventive intervention, and treatment. This innovative training series offers Monterey County professionals the following outcomes:

1. Foundational skills and knowledge related to the basic theories of social, emotional and developmental needs of infants, young children, and their families, as well as assessment and intervention techniques for this population;
2. Shared understanding in relationship-based practices across systems and disciplines serving children, prenatal through age 5 and their families; and
3. Endorsement by the California Center for Infant-Family and Early Childhood Mental Health as a Mental Health Specialist (MHS), Transdisciplinary Mental Health Practitioner (TMHP), and/or Reflective Practice Facilitator (RPF) qualified to work in the infant-family and early childhood mental health field.

As in previous years, response data were collected from current-year participants, in this case the 2015–2016 IFECMH Training Program (Year Four). Data were collected from three cohorts: transdisciplinary providers working in health care, early care and education, and other systems focused on the well-being of infants, young children, and their families (TMHP A and TMHP B) and mental health providers working in mental health treatment programs and other treatment and consultation programs in which the well-being of children birth to age 5 is a primary focus (MHS). Unless there were substantive differences between cohorts TMHP A and TMHP B, responses for these two cohorts were aggregated as "TMHP."

Of the Year Four respondents (N=112), 25 percent had participated in 2012–2013, 40 percent in 2013–2014, and 54 percent in 2014–2015. Consistent with Years One through Three, participants in Year Four gave high ratings to the program, placing value on the training content, format, and instruction. Key findings in each of the three outcome areas are highlighted below.

Outcome 1: Foundational skills and knowledge

Among the MHS respondents, 100 percent found that participation in the program increased their knowledge of how to work with children and their families (81 percent strongly agreed; 19 percent agreed). For the TMHP respondents, the majority reported that participation in the program resulted in an increase in knowledge (69 percent strongly agreed; 24 percent agreed).

Most importantly, a majority of each cohort reported that they had applied knowledge gained in the program to expand ways in which they work with children and their families (TMHP: 72 percent strongly agreed, 28 percent agreed; MHS: 56 percent strongly agreed, 36 percent agreed).

Outcome 2: Shared understanding in relationship-based practices across systems and disciplines

Nearly all MHS participants (93 percent) and the majority of TMHP participants (86 percent) reported the added benefit of meeting and networking with colleagues from partner agencies.

More specifically, nearly all MHS participants (96 percent) and the majority of TMHP participants (90 percent) reported that they learned about new resources from other training group members. Among the MHS participants, 41 percent shared new information they learned with families they serve; 30 percent made a referral for a family as a result of learning about new community resources. In the TMHP cohorts, 58 percent shared new information they learned (from other group members) with the families they served; 44 percent made a referral for a family as a result.

When compared to cohorts from the previous year, MHS respondents in Year Four increased referral rates by 2 percent (Year Four=30 percent, Year Three=28 percent). Among TMHP participants, cohorts A and B in Year Three had vastly different reports of referrals (TMHP A=65 percent, TMHP B=35 percent), whereas TMHP participants in Year Four had similar rates to one another (TMHP A=43 percent, TMHP B=44 percent). On average, Year Three TMHP participants made slightly more referrals than Year Four (Year Three TMHP=50 percent, Year Four THMP=44 percent).

Outcome 3: IFECMH practitioner endorsement support

Participation in the training program continued to prompt interest in the California Center for Infant-Family and Early Childhood endorsement process, albeit at a slightly lower rate than in previous years.

For example, as compared to 75 percent of the MHS cohort and 82 percent of the TMHP cohort in Year Three, 51 percent of MHS participants and 61 percent of TMHP participants in Year Four viewed information about the competencies, skills, and practices recommended by the California Center for Infant-Family and Early Childhood Mental Health in its *California Training Guidelines and Personnel Standards for Infant-Family and Early Childhood Mental Health (Revised*), which defines standards for the infant-family and early childhood mental health specialization and provides resources to build skills to support children's social-emotional and developmental well-being. This decrease may be due to the fact that participants who had attended the IFECMH in previous years had already viewed the website and were familiar with the guidelines and competencies.

Participants in Year Four also took the steps of reviewing the endorsement application materials (MHS=50 percent, TMHP=44 percent) and gathering supporting documents for the application

package (MHS=41 percent, TMHP=25 percent). In Year Three, 63 percentof the MHS cohort began collecting supporting documents and 58 percent of the TMHP group did so.

In total, three participants submitted applications for endorsement, equal to the number of participants who submitted applications in Year Three.

Among MHS participants, 5 percent reported that they gained endorsement at the Transdisciplinary Mental Health Practitioner level, 10 percent gained endorsement at the Mental Health Specialist level, and 5 percent gained endorsement at the Reflective Practitioner II level (RPF II). Among TMHP participants, 13 percent achieved endorsement at the Transdisciplinary Mental Health Practitioner level.

Both individual and final survey responses from Year Four participants in the Foundations of Infant-Family and Early Childhood Mental Health Training Program show strong evidence of the value of the program. Most notably, participants repeatedly cited the value of cross-disciplinary interactions, as well as the opportunity for reflective practice and the deepening of their knowledge base in early childhood mental health issues.

Introduction

Professionals working with young children require specialized training and reflective practice opportunities in order to best support young children and their families. Over the last decade, experts in California and throughout the country have worked to clarify the knowledge, skills and competencies needed to provide effective infant-family and early childhood mental health services. In 2009, the California Center for Infant-Family and Early Childhood Mental Health published *California Training Guidelines and Personnel Standards for Infant-Family and Early Childhood Mental Health (Revised)* to identify the information and skills needed to support the professional development of practitioners working with young children and their families.

The First 5 Monterey County Commission recognized the need to develop ongoing capacity in the field of infant-family and early childhood mental health. After conducting a four-session pilot, the Commission embarked on a multi-year Foundations of Infant-Family and Early Childhood Mental Health (IFECMH) Training Program.

The IFECMH Training Program was designed to strengthen the capacity of the diverse workforce of partners across systems serving children, prenatal through age 5, and their families, in order to build mental health expertise along the continuum of promotion, preventive intervention, and treatment. The series is based on the *California Training Guidelines and Personnel Standards for Infant-Family and Early Childhood Mental Health (Revised),* which defines standards for the infant-family and early childhood mental health specialization and provides resources to build skills to support children's social-emotional and developmental well-being. This integrated training series was designed to provide Monterey County professionals, specifically selected by First 5 Monterey County through an application process, with the following: 1) foundational skills and knowledge related to the basic theories of social, emotional and developmental needs of infants, young children and their families, as well as assessment and intervention techniques for this population; 2) shared understanding of relationship-based practices across systems and disciplines serving children, prenatal through age 5 and their families; and 3) endorsement by the California Center for Infant-Family and Early Childhood Mental Health as a Mental Health Specialist (MHS), Transdisciplinary Mental Health Practitioner (TMHP), and/or Reflective Practice Facilitator (RPF) qualified to work in the field of infant-family and early childhood mental health. This report summarizes findings from 2015–2016 and compares findings on key items across the four years of the training initiative.

Background

Methodology

This report reflects data collected from training participants in 2015/2016, Year Four of the initiative, and provides some comparisons to data collected in the previous three years. Across all four years, data were gathered from both individual session surveys and an end-of-year evaluation survey. Participants completed individual session surveys at the conclusion of each of the six sessions, totalling 486 individual session surveys completed in 2015–2016. Participants completed the final evaluation electronically through Survey Monkey; the survey was open to participants from April 13, 2016 through May 12, 2016, allowing sufficient time for participants to complete this task. Among all three cohorts, 112 participants responded to the final survey, reflecting a response rate of 93%. Thirty MHS participants and 82 TMHP participants completed the survey. This document reports response data as the percentage of participants or the number of participants, as appropriate.

The final evaluation included 22 items (note: one item was not analyzed due to mislabeling of the response options, resulting in 21 items available for analysis). The individual session survey included 9 items. Both survey instruments were comprised of a combination of Likert scale statements, open-ended questions, and questions that required a yes or no response. In the final evaluation, the Likert scale included five response options: strongly disagree, disagree, agree, strongly agree, and not applicable. The Likert scale response options for the individual session surveys were absolutely, somewhat, uncertain, probably not, or absolutely not.

Participant Demographics

2015–2016

Participants in the Year Four training series were divided into three cohorts. They included mental health providers working in mental health treatment programs and other treatment and consultation programs in which the well-being of children birth to age 5 is a primary focus (MHS) and transdisciplinary providers working in health care, early care and education, and other systems focused on the well-being of infants, young children, and their families (TMHP A and TMHP B). Unless there were substantive differences between cohorts TMHP A and TMHP B, responses for these two cohorts were aggregated as "TMHP."

A total of 123 Monterey County professionals participated in the series (MHS=37, TMHP A=43 TMHP B=43). Of the Year Four respondents to the evaluation survey (N=112), 25 percent had participated in 2012/2013, 40 percent in 2013/2014, and 54 percent in 2014/2015.

Three California Center for Infant Family and Early Childhood Mental Health (CA Center) Reflective Practice Mentors (RPMs), well-known experts in the field of infant and early childhood mental health, conducted the training in seven sessions: one orientation day and six full-day training sessions.

Mental Health Specialist (MHS)

The MHS cohort included 37 participants primarily composed of clinical staff, including therapists, clinical social workers, consultants, psychologists, program directors/supervisors, health coordinators, and parent educators.

Transdisciplinary Mental Health Practitioner (TMHP)

Consistent with previous years, there are differences in the professions represented by participants in the two TMHP cohorts. For the most part, participants were organized into two unique cohorts in order to reduce class size and tailor the topics and readings to the working context of each group.

TMHP A (n=43) consisted primarily of early child care professionals, including teachers, supervisors/coordinators, early childhood education consultants, and parent educators.

TMHP B (n=43) included a diverse group of allied health care and social service professionals, as well as educators. They included service coordinators/case managers, teachers, nurses, parent educators, family support workers, clinicians, a pediatrician, and a probation officer.

Previous Cohorts

Table 1 provides enrollment data across all four years of the program.

Table 1: IFECMH Enrollment

	MHS	TMHP
Year 1	38	48
Year 2	36	68
Year 3	45	76
Year 4	37	86

Year One (2012-2013)

Year One included 86 participants (MHS=38, TMHP=48). Two California Center reflective practice mentors provided the training for the two cohorts in seven sessions: an orientation day and six full-day training sessions.

Year Two (2013-2014)

Year Two included 104 participants (MHS=36, TMHP=68). Due to the large number of THMP participants, their group was divided into two cohorts (TMHP A=35, TMHP B=33). As a result, three California Center RPMs facilitated the training in six full-day training sessions.

Year Three (2014-2015)

Year Three included 121 participants (MHS=45, TMHP=76). The TMHP group was again divided into two cohorts – not only due to the size of the group, but also to provide more tailored training based on the working context of each cohort (TMHP A=44, TMHP B=32).

Participation in the Series

Series Structure

In 2015/2016, the training program consisted of an orientation session, six full-day training sessions (see Table 2), reading assignments, reflective practice groups, and technical assistance for the endorsement portfolio review. Participants received credit toward the IFECMH Competencies and continuing education units for their participation.

Table 2. Training Session Topics by Cohort

	MHS	TMHP A	TMHP B
September	Program Orientation and Introduction to Relationship-Based Approaches and Reflective Practice	Program Orientation and Introduction to Relationship-Based Approaches and Reflective Practice	Program Orientation and Introduction to Relationship-Based Approaches and Reflective Practice
October	The Impact of Trauma and Community Violence on the Development, Health and Well-Being of Young Children	Powerful Socio-Cultural Contexts That Impact the Development of Infants and Young Children	The Impact of Trauma and Community Violence on the Health and Well-Being of Families with Young Children
November	Addressing Multiple Needs of Infants and Young Children Across Systems	The Dynamic Process of How Families Influence the Child's Social and Emotional Development	Cultural Competency or Cultural Humility? Boundaries and Use of Self
January	Understanding and Using Play as a Tool for Growth and Healing	When Parents Are Hurting: Understanding the Child's Perspective	The Interplay Between Biological and Psychosocial Factors
February	Rebuilding a Sense of Safety After Physical or Sexual Abuse	Tracing the Roots of Social-Emotional Problems in Young Children	Parental Depression and the Impact on Child Development
March	Loss and Longing in Young Children	What We Need to Know About Child Health and Disability	Redefining Fatherhood

April	Using Reflective Capacity to Address Ethical Issues in Infant and Early Childhood Mental Health Practice	It's Never Easy: Managing Boundary Issues	Developmental Disabilities: Early Identification and Access to Support Services

Attendance

MHS cohort attendance averaged 23 participants per session, TMHP A attendance averaged 30 participants, and TMHP B averaged 29 participants. Table 3 illustrates attendance per group per session, including the orientation session in September.

Table 3. Attendance Per Training Session

	TMHP	MHS
September	**46**	**15**
October	**74**	**25**
November	**69**	**27**
January	**55**	**23**
February	**59**	**23**
March	**55**	**24**
April	**61**	**21**

Readings and Assignments

Prior to each session, participants received relevant journal articles and readings. In addition, they were encouraged to answer reflective questions about the readings, for which they received additional credit once submitted. Though the readings and reflective assignments were not mandatory, the majority of participants reported reading some or all of the material (MHS=78 percent, TMHP A=70 percent, TMHP B=85 percent), with a lower rate of completion for the written assignments (MHS=26 percent, TMHP A=47 percent, TMHP B=35 percent). For those who engaged in these activities, the majority of participants found that the readings enhanced what they learned in the training sessions (MHS=91 percent, TMHP A=95 percent, TMHP B=97 percent). All cohorts reported positively about the transfer of learning: 96 percent of the MHS participants and 97 percent of the TMHP cohort reported that they applied information from the readings to their work.

> *I have greatly enjoyed the readings, and the deeper understanding of mental health and resilience issues has increased my ability to articulate issues as I talk with colleagues, parents, and other professionals. I have also enjoyed the camaraderie and increased knowledge gained from the multidisciplinary make-up of classes.*
>
> *Participant comment*

Case Conference Small Groups

These cross-disciplinary small groups were a new feature of the 2015-2016 program. Participants from the A, B, and C cohorts were combined to form groups of approximately 8 participants for structured case discussions designed to promote multidisciplinary thinking, build reflective skills, increase knowledge of multiple systems and build connections across programs and systems. At each session, participants received a case study that expanded upon the topics and themes of the day. Facilitators posed reflective questions to encourage discussion among participants. A specialized group of advanced practitioners in training, called Capstone leaders, collaborated with the Reflective Practice Mentors to facilitate the small groups.

Capstone Leadership Group

Year Four saw the commencement of a new phase of the training initiative, the Capstone Leadership Group, in a move to expand the number of individuals in Monterey County (both Transdisciplinary Mental Health Providers and Mental Health Specialists) able to support the growth and learning of others in the field of infant-family and early childhood mental health. The Capstone Leadership Group consisted of 16 individuals who facilitated small group case conferences or co-facilitated the reflective practice groups with one of the primary instructors. These facilitation opportunities were designed to expand and deepen skills for participants who had achieved endorsement by the California Center for Infant-Family and Early Childhood Mental Health or who were in the process of applying for endorsement and desired opportunities for growth in facilitation, supervision, and teaching. Capstone leaders used the Facilitating Attuned Interaction (FAN) model to guide their groups. To prepare for the case conference small groups, Capstone leaders received cross-disciplinary materials and the case study in advance. They also participated in Friday morning learning sessions using a group facilitation model and met at lunch on Saturday just before the sessions. After each session they engaged in self-assessment and reflection, as well as follow-up by email or phone calls. Hours spent in self-assessments, preparation and follow-up with the cohort facilitators were logged for reflective practice hours for Reflective Practice Facilitator I, II or Mentor endorsement.

Outcome One: Foundational Skills and Knowledge

Foundational skills and knowledge in infant-family early childhood mental health are related to the basic theories of social, emotional and developmental needs of infants, young children and their families and assessment and intervention techniques for infant-family and early childhood mental health services. The change in participants' foundational skills and knowledge in their work with young children and their families was assessed using self-reported individual session surveys and end-of-year evaluations.

Overall Impact of Training Series

As in previous years, participants acknowledged the strong impact of the training series on their professional knowledge and skills. Among the MHS respondents, 100 percent found that participation in the program increased their knowledge of how to work with children and their families (81 percent strongly agreed; 19 percent agreed). For the TMHP respondents, the majority reported that participation in the program resulted in an increase in knowledge (69 percent strongly; 24 percent agreed). Most importantly, a majority of each cohort reported that they had applied knowledge gained in the program to expand ways in which they work with children and their families (TMHP: 72 percent strongly agreed, 28 percent agreed; MHS: 56 percent strongly agreed, 36 percent agreed). Figures 1 and 2 depict participants' responses by cohort.

Figure 1. Overall Impact of Training by Cohort

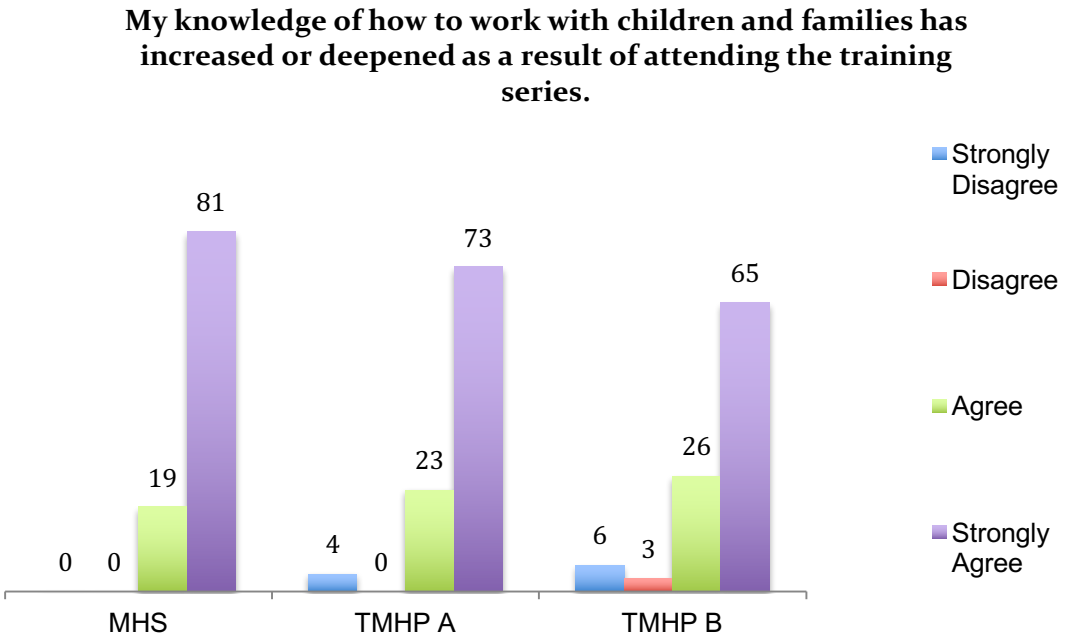
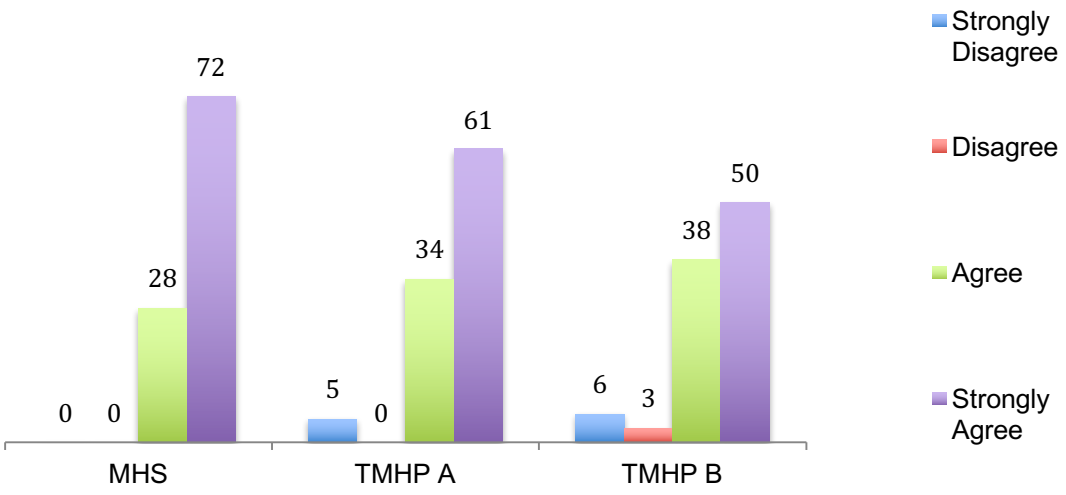
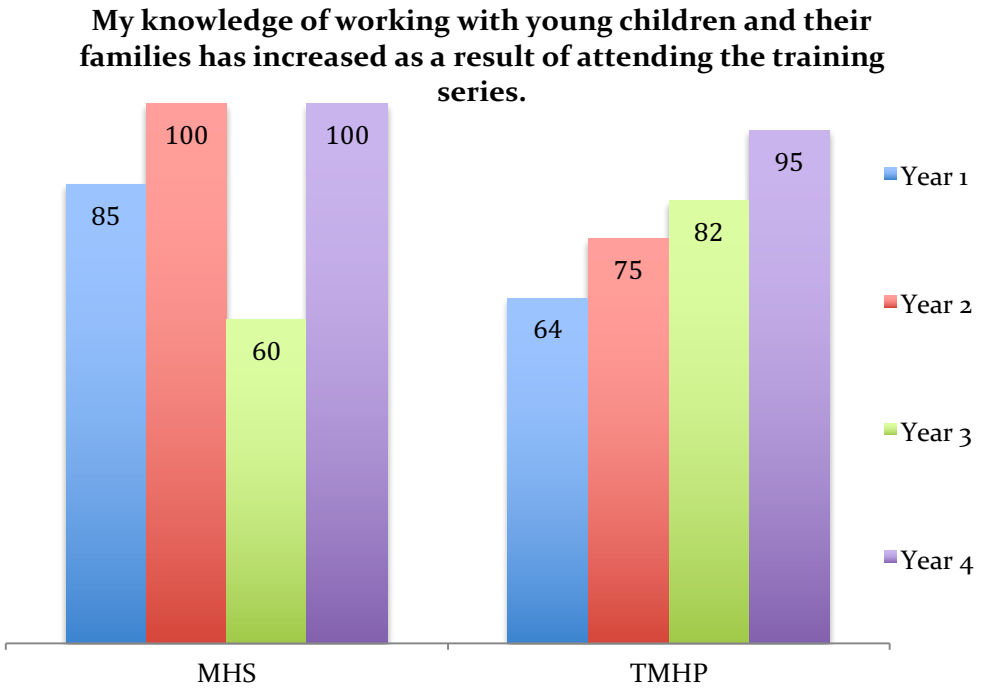


Figure 2. Overall Impact of Training by Cohort (continued)



In a comparison of responses (see Figure 3), TMHP respondents in Year Four rated their increase in knowledge higher than in any previous year (95 percent in Year Four versus 64 percent in Year One, 75 percent in Year Two, and 82 percent in Year Three). MHS responses in Year Four matched responses from Year Two: 100 percent agreed that their knowledge of working with young children and their families had increased as a result of attending the training series.

Figure 3. Impact of Training Years One Through Four



Sample comments from participants in Year Four provide qualitative data about the impact of the IFECMH training program:

- *As a nurse and a parent, I really enjoy the trainings. I wish I could bring my husband and other family members with me to learn the topics we cover and why the first five years of a child's life are so important.*

- *This training has been very helpful and rewarding for me as I begin my journey working with children 0-5 and their families. It has helped me have awareness in so many different aspects of child development, including having empathy and understanding for the parents who have experienced their own trauma and how this may impact their relationship with their child. It has also increased my motivation to continue working in the MH field. Thank you for the opportunity to learn and grow professionally.*

Impact of Individual Sessions

As in Year Three, all Year Four respondents agreed that the individual workshop sessions met their needs. Participants in all three groups rated the session topics in which they felt they had expanded or grown in their knowledge and skills. As each group syllabus and the corresponding presenter was different, results are reported separately for the MHS cohort, TMHP A, and TMHP B.

The most highly rated topic for MHS respondents was "Trauma and Its Impact on Development" (68 percent), followed by "Attachment/Relationships" (44 percent) and "Play" (44 percent). TMHP A respondents found that "Ethics/Boundaries in Intervention Settings" (57 percent) most expanded their knowledge and skills, followed by "Attachment/Relationships" (55 percent) and "Trauma and Its Impact on Development" (41 percent). In the TMHP B cohort, "Trauma and Its Impact on Development" received the highest rating (56 percent). Three topics received the same rating (38 percent): "Fatherhood," "Attachment/Relationships," and "Adverse Childhood Experiences."

Effectiveness of Reflective Practice Facilitation Groups

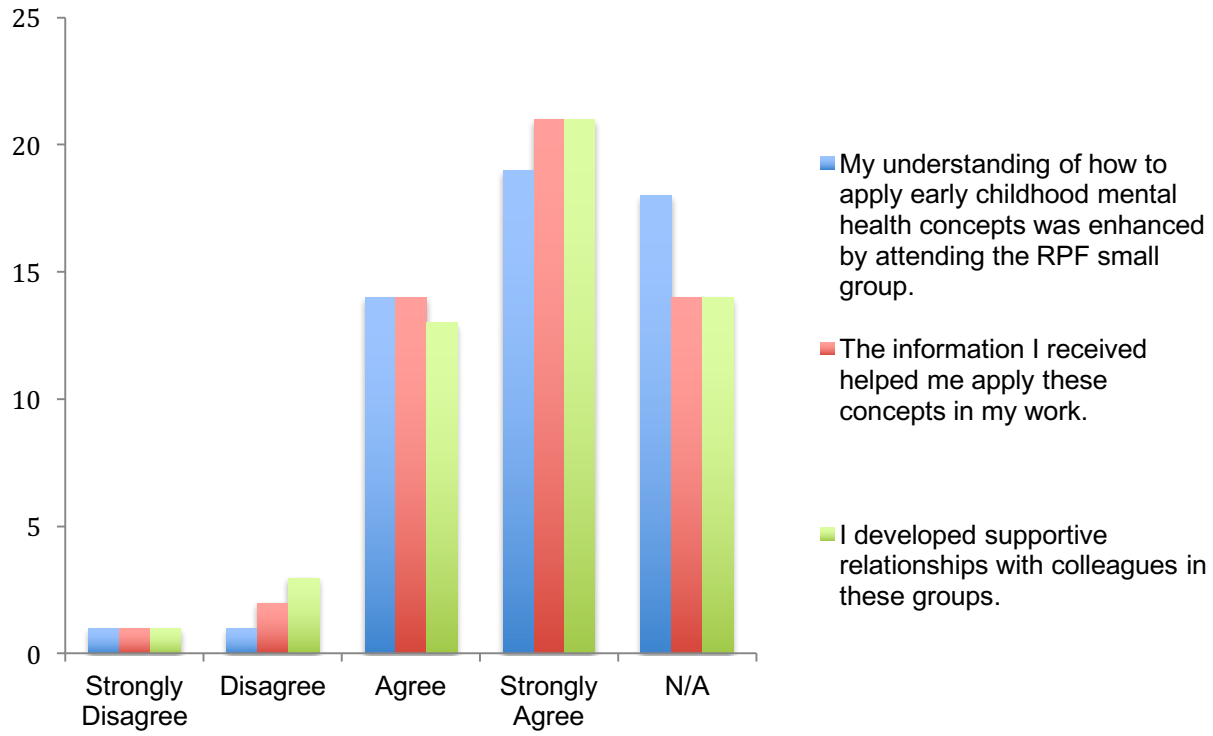
Participation in reflective practice facilitation is a required component of the California Center Infant-Family and Early Childhood Mental Health endorsement process. In Monterey County, participation in reflective practice is a scope of work requirement for most First 5 Monterey County funded partners. Recognizing that reflective practice is an integral component of infant-family and early childhood mental health practice, the training program included regular opportunities to focus on both the content and process of IFEMCH work.

In addition to the reflective practice focus of the training sessions, participants were given the opportunity to understand and build skills in reflective practice facilitation. Each cohort had two reflective practice small groups (with a maximum of eight participants) – one that met on Friday

nights and another that met on Saturday afternoons – for a total of six reflective practice groups per cohort.

Of the 112 respondents to the final survey, 36 reported that they had attended the small group reflective practice facilitation (MCH=11, TMHP A=16, TMHP=9). Of this group, 62 percent reported that attendance in reflective practice facilitation groups enhanced their understanding of how to apply early childhood mental health concepts; 67 percent agreed or strongly agreed that the information received in the groups helped them apply these concepts in their work. Sixty-five percent of RPF participants agreed or strongly agreed with the statement, "I developed supportive relationships with colleagues in these groups." Figure 4 illustrates the aggregated responses to this set of statements. Overall, many of the stories participants shared in the final evaluation emphasized the value of reflective practice. Refer to the Appendix for samples of these stories.

Figure 4. Response to Small Group Reflective Practice Facilitation



Success of Capstone Leadership Group

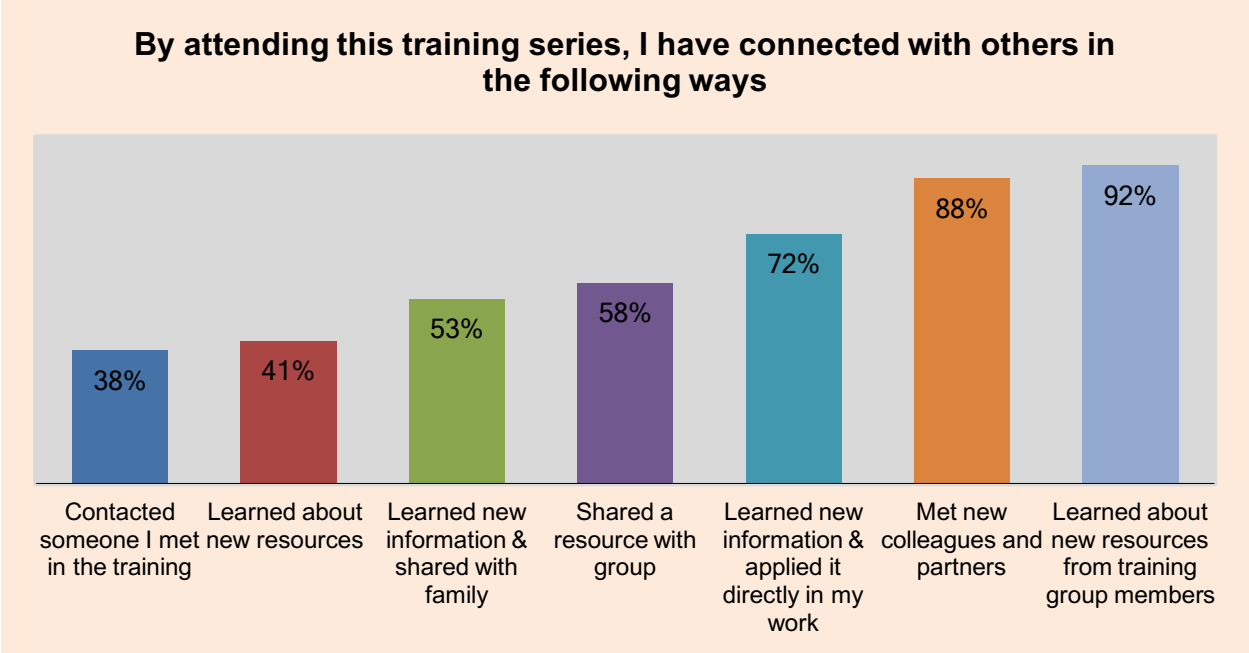
Capstone participants reported very favorable responses to this new component of the training program. One hundred percent of participants from the MHS cohort agreed or strongly agreed that they were able to use the FAN model to guide their groups. From the TMHP cohort, 84 percent reported the same. Overall, 92 percent of the Capstone participants agreed or strongly agreed with the statement, "Capstone meetings gave me opportunities to learn new skills about group facilitation." Although 23 percent of respondents felt they needed more support and training as a reflective facilitator, 92 percent felt they had observed growth in their own skills as a facilitator.

Outcome Two: Shared Understanding in Relationship-Based Practices Across Systems and Disciplines Serving Young Children

As in previous years, the experience of bringing together professionals from across Monterey County for the training series resulted in the opportunity to meet new colleagues and partners in infant-family and early childhood mental health work. Participants worked together over six sessions, forming relationships, gaining a greater understanding of other professional viewpoints, and learning about one another's systems and resources. In fact, 88 percent of the group reported that they met new colleagues through participation in the training program.

Nearly all MHS participants (93 percent) and the majority of TMHP participants (86 percent) reported an added benefit of meeting and networking with colleagues from partner agencies. More specifically, nearly all MHS participants (96 percent) and the majority of TMHP participants (90 percent) reported that they learned about new resources from other training group members. Among the MHS participants, 30 percent made a referral for a family as a result of learning about these community resources. An additional 41 percent shared new information they learned from colleagues with families they serve. For the TMHP participants, 90 percent learned about new resources from other training group members; 44 percent made a referral for a family as a result. Fifty-eight percent of TMHP participants reported that they learned new information from other group members and shared that information with families. Figure 5 provides additional detail of the aggregated participant responses to this set of statements on cross-disciplinary interaction during the training program.

Figure 5. Cross-Disciplinary Learning



When compared to cohorts from the previous year, MHS respondents in Year Four increased referrals by 2 percent (Year Four=30 percent, Year Three=28 percent). Among TMHP participants, Year Four referrals decreased by 6 percent when compared to the Year Three cohort (Year Three TMHP=50 percent, Year Four THMP=44 percent). Interestingly, TMHP cohorts A and B in Year Three had vastly different reports of referrals (TMHP A=65 percent, TMHP B=35 percent), whereas TMHP participants in Year Four had similar rates to one another (TMHP A=43 percent, TMHP B=44 percent).

Finally, participants repeatedly stressed the benefit of interacting with colleagues from diverse disciplines. Their written feedback included:

- I enjoyed the last session of the day – getting together with individuals from different areas/fields and listening and getting different ideas to support families. Enjoyed the interaction and wealth of information.
- Liked afternoon activity – talking across disciplines.
- Vignette collaboration – excellent opportunity to learn about other perspectives, approaches, etc.
- I learned most from the group participants. I love the diversity of experience.

Outcome Three: IFECMH Practitioner Endorsement

An overview of the California Infant-Family and Early Childhood Mental Health Center (California Center) competencies and endorsement process presented in the orientation session and each training session was drawn from the *California Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health (Revised)*. Individuals receive endorsement from the California Center in three general categories. The cohorts for the training series are based on the endorsement areas of:

Mental Health Specialist (MHS). Professionals who hold, or are seeking, a professional license or credential from a state regulatory agency including, but not limited to, professionals in the mental health field who provide prenatal, infant-family, and early childhood mental health services within their scope of practice in the areas of promotion, preventive intervention and treatment.

Transdisciplinary Mental Health Practitioners (TMHP). Professionals from multiple human development and education disciplines who work with pregnant women, infants, toddlers and preschoolers and their families. Disciplines include teaching, early intervention, nursing, occupational or physical therapy, special education, social work, pediatrics and early education.

Reflective Practice Facilitators (RPF). Mental Health Specialists *(RPF-I)* and Transdisciplinary Mental Health Practitioners *(RPF-II)* who provide reflective practice to others. The increased availability of qualified Reflective Practice Facilitators will support sustained ongoing reflective facilitation among practitioners serving young children and families in Monterey County.

Endorsement is an important designation as it indicates that an individual has achieved an accepted level of specialization in a field. This specialization ensures programs and funders that staff providing a service are prepared and endorsed in a specialty area. Licensure is required for many mental health professions, but licensure alone does not ensure competence in infant-family and early childhood mental health.

Participation in the IFECMH training program continued to prompt interest and progress in the California Center Infant-Family and Early Childhood endorsement process, albeit at a lower rate when compared to the previous year. For example, 61 percent of TMHP and 51 percent of MHS respondents in Year Four viewed information about the training guidelines and competencies on the California Center for Infant-Family and Early Childhood Mental Health website. In Year Three, 82 percent of TMHP participants and 75 percent of MHS participants viewed the information.

Participants in Year Four also took the steps of reviewing the endorsement application materials (MHS=50 percent, TMHP=44 percent) and gathering supporting documents for the application package for endorsement (MHS=41 percent, TMHP=25 percent). In Year Three, 63 percent of the

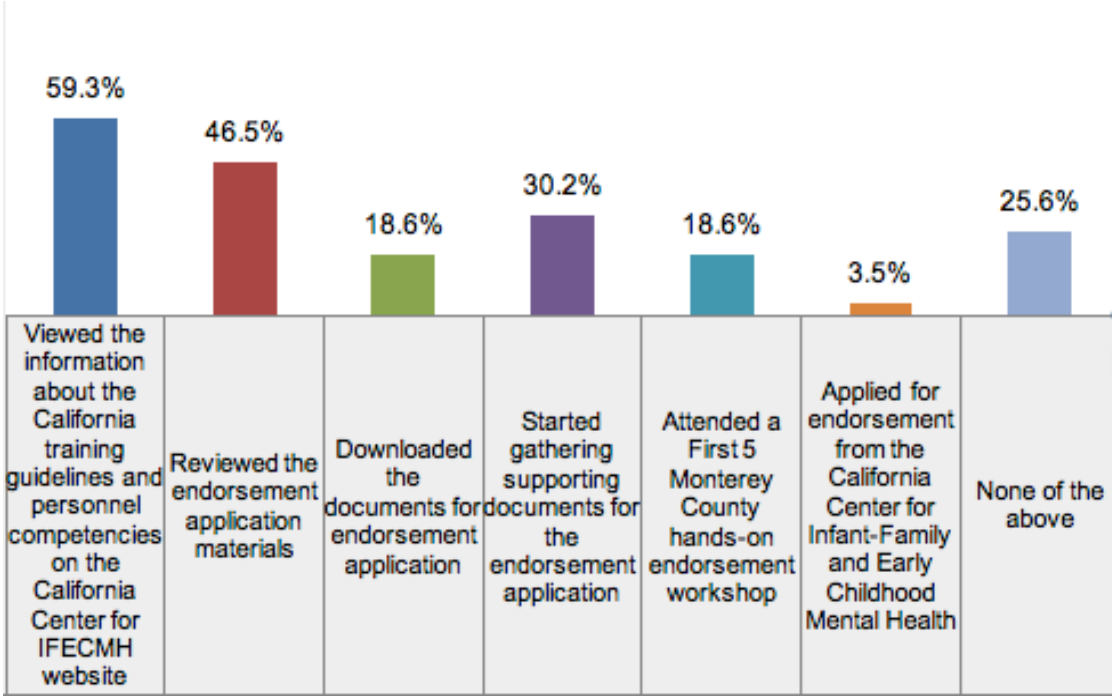
MHS cohort began collecting supporting documents and 58 percent of the TMHP group did so. Three participants in Year Four submitted applications for endorsement, equal to the number of participants who submitted applications in Year Three.

Within the group, Year Four respondents varied in how far they pursued the endorsement process, ranging from viewing the information on the website to applying for endorsement. Half of the MHS participants took the step of reviewing endorsement application materials; whereas, less than half of the TMHP participants did so (MHS=50 percent, TMHP=44 percent). Among MHS respondents, 41 percent gathered supporting documents for the endorsement application, compared to 23 percent in TMHP A and 29 percent in TMHP B.

> *Although I have received endorsement I still strongly agree that the trainings and informational topics provided ensure that I continue to provide the best practices and resources to all families served.*
>
> *Participant comment*

Among MHS participants, 5 percent gained endorsement at the Transdisciplinary Mental Health Practitioner level, 10 percent gained endorsement at the Mental Health Specialist level, and 5 percent gained endorsement at the Reflective Practitioner II level. Among TMHP participants, 13 percent achieved endorsement at the Transdisciplinary Mental Health Practitioner level.

Figure 6. Year Four Progress Toward Endorsement



Participant Satisfaction

Individual Session Evaluation

After each of the six training sessions, participants completed a session evaluation about the presenter, session content and its relevance, and materials provided. The survey was comprised of open-ended questions and Likert-type statements. Survey responses for the six sessions were aggregated by cohort and are reported below.

Mental Health Specialist (MHS)

Aggregated results for the MHS cohort indicate that 100 percent agreed that the workshop sessions met their needs. Ninety-seven percent of MHS respondents agreed that the presenter was knowledgeable of the subject matter. Eighty-eight percent of MHS respondents agreed that the information was well-organized and presented in a manner that could be understood; 95 percent found the information useful and relevant. In this same cohort, 88 percent found the handouts and visual aids helpful in understanding the material.

When asked, "What was the most valuable feature of this presentation?" MHS respondents cited the following:

- Time to reflect and experience more than one way to view something.
- Becoming more attuned with feelings, emotions, stress; to be able to provide proper support, with limits and boundaries.
- Hearing the experience of others regarding ethical dilemmas.
- Discussion of the variety of losses children can experience in their lives.
- Interactive exercises with others and facilitated discussions.

Many MHS respondents specifically referred to the value of the vignette discussions as well as the use of videos in the trainings:

- I particularly enjoyed the afternoon session using the vignettes and connecting with other professionals.
- Good discussion, loved the videos.
- Discussion about vignettes on how to help children deal with loss.
- Discussion with the training group about the small vignettes.

When asked, "How do you think the presentation could have been improved?" many MHS respondents mentioned the challenge of addressing the topic within a limited timeframe:

- I think it is always difficult to cover such a broad topic in a few hours, but this was a good introduction.

- Morning session had so much to cover that we were unable to go into depth on topics.
- Limiting the goals for morning session in order to fully develop them.

Another theme raised in the responses suggested a desire for more in-depth information about intervention:

- More focus on interventions that could be used would be helpful (about processing loss).
- More focused on interventions.
- Maternal unit and engaging mothers in services.
- I would like to have more small group time and activities. I would like to have more interventions (tips, etc).

Transdisciplinary Mental Health Practitioner (TMHP)

All TMHP respondents (100 percent) agreed that the workshop sessions met their needs. TMHP respondents in both cohorts agreed that the presenter was knowledgeable of the subject matter (98 percent) and that the information presented was useful and relevant (95 percent). However, there was some variation in cohort responses to other survey statements. For example, 97 percent of TMHP A agreed that the training was well-organized, whereas 91 percent of Group B agreed with the statement. In addition, 97 percent of Group A found the handouts and visual aids helpful as compared to 90 percent of Group B respondents. Figure 7 provides additional detail concerning cohort ratings of the training sessions.

When asked, "What was the most valuable feature of this presentation?" many participants commented on the structure of the training and the opportunities for engagement and discussion:

- Everything was valuable including the conversations and videos.
- Group discussion with vignettes.
- The discussion on how to engage fathers more.
- Group interaction, where difficult ideas can be shared.
- I really enjoyed the last part talking about the vignette.
- The sharing and discussion about the case studies.

In response to the question, "How do you think the presentation could have been improved?" many TMHP respondents, like the MHS cohort, commented on the time element:

- More time to discuss the vignette in a large group.
- The time was too short.
- More time discussing with other service providers.
- More time to get deeper into this subject; it's a big topic.

At the same time, many responses to this question reflected the high degree of participant satisfaction:

- I think the presentation was great and informative.
- All the information was important and it gave me a better understanding of depression.
- I really enjoyed everything about it.
- Very interesting topic, dynamic training.
- It was excellent!

Overall, participant responses to the open-ended questions were consistent with ratings given for the Likert-type statements in both the individual surveys and the final evaluation. In all three cohorts, participants expressed a high degree of satisfaction with the individual training sessions.

Summary of Findings

All three cohorts gave consistently favorable ratings and positive comments about the IFECMH training program. Based on their collective responses, the training program successfully addressed the three outcomes approved by the First 5 Monterey County Commission. This section of the report summarizes key findings, both within the 2015-2016 cohorts and across years.

Outcomes

Outcome One: Foundational skills and knowledge

Among the MHS respondents, 100 percent found that participation in the program increased their knowledge of how to work with children and their families (81 percent strongly agreed; 19 percent agreed). For the TMHP respondents, the majority reported that participation in the program resulted in an increase in knowledge (69 percent strongly agreed; 24 percent agreed).

In a comparison of responses from Years One through Three, TMHP respondents in Year Four rated their increase in knowledge higher than in any previous year (95 percent in Year Four versus 64 percent in Year One, 75 percent in Year Two, and 82 percent in Year Three). MHS responses in Year Four matched responses from Year Two at 100 percent.

More importantly, a majority of each cohort in Year Four reported that they had applied knowledge gained in the program to expand ways in which they work with children and their families (MHS: 56 percent strongly agreed, 36 percent agreed; TMHP: 72 percent strongly agreed, 28 percent agreed). This transfer of learning from the training setting to the workplace is a key feature of long-term, sustainable improvements in professional practice.

Outcome Two: Shared understanding in relationship-based practices across systems and disciplines serving young children

Nearly all MHS participants (93 percent) and the majority of TMHP participants (86 percent) reported an added benefit of meeting and networking with colleagues from partner agencies. More specifically, 96 percent of MHS participants and the majority of TMHP participants (90 percent) reported that they learned about new resources from other training group members. Among the MHS participants, 30 percent made a referral for a family as a result of learning about these community resources. An additional 41 percent shared new information they learned from other participants with families they serve. For the TMHP participants, 90 percent learned about new resources from other training group members; 44 percent made a referral for a family as a result. Fifty-eight percent of TMHP participants reported that they learned new information from other group members and shared that information with families.

An important example of participants' transfer of learning from the training setting to the workplace is reflected in their survey responses: 70 percent of MHS participants agreed that they "learned new information from a training group member and applied it directly in my work."

Cohorts A and B had different responses to the same statement: 82 percent of TMHP A agreed with this statement, whereas, 59 percent of TMHP B did so.

Outcome Three: IFECMH Practitioner Endorsement

Participation in the training program continued to prompt interest and progress in the California Center Infant-Family and Early Childhood endorsement process, albeit at a lower rate when compared to Years Two and Three. For example, 61 percent of TMHP and 51 percent of MHS respondents in Year Four viewed information about the training guidelines and competencies on the California Center for Infant-Family and Early Childhood Mental Health website. In Year Three, 82 percent of TMHP participants and 75 percent of MHS participants viewed the information.

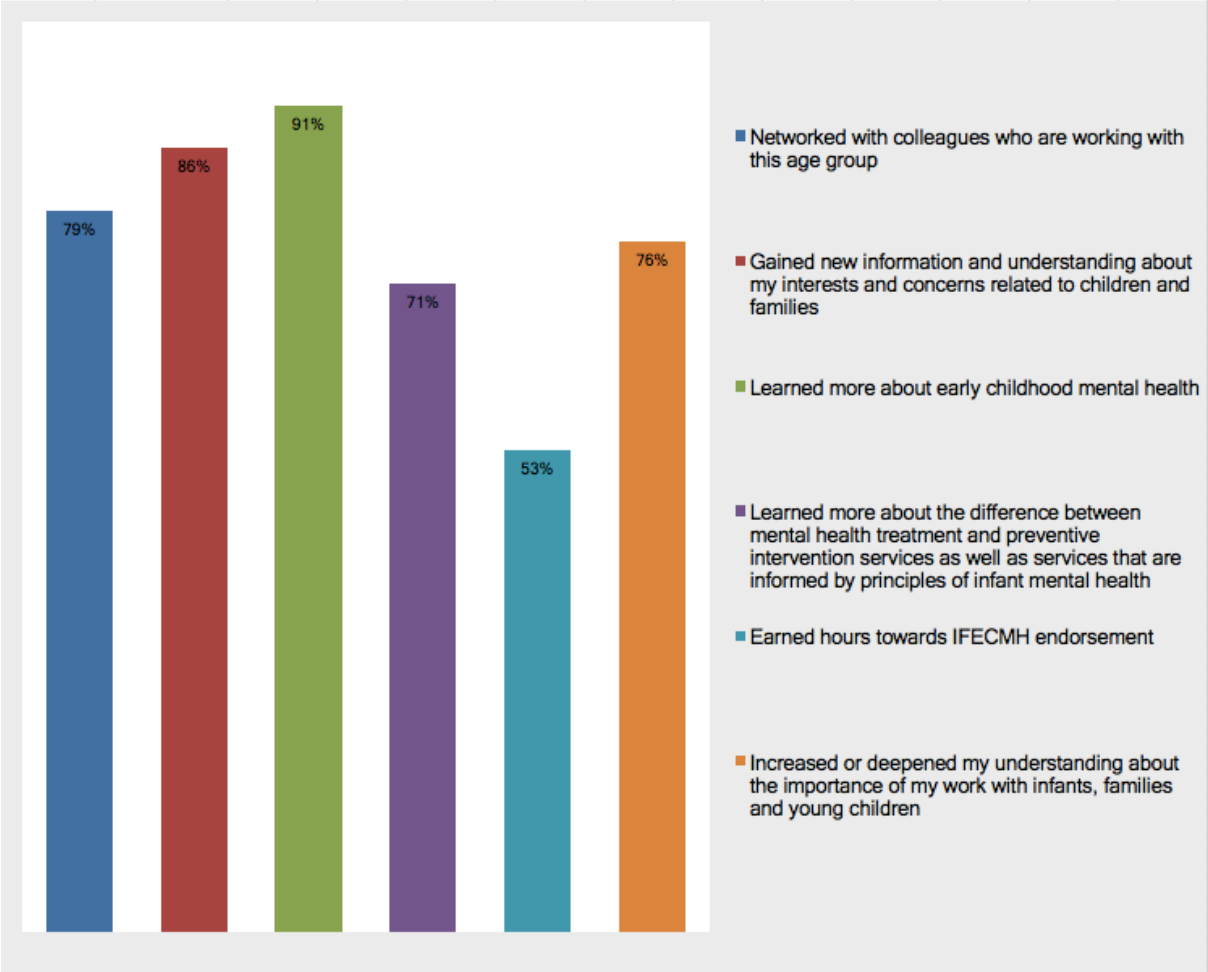
Within the group, Year Four respondents varied in how far they pursued the endorsement process, ranging from viewing information on the website to applying for endorsement. Half of the MHS participants took the step of reviewing endorsement application materials; whereas, less than half of the TMHP participants did so (MHS=50 percent, TMHP=44 percent). Among MHS respondents, 41 percent gathered supporting documents for the endorsement application, compared to 23 percent in TMHP A and 29 percent in TMHP B.

Among MHS participants, 5 percent gained endorsement at the Transdisciplinary Mental Health Practitioner level, 10 percent gained endorsement at the Mental Health Specialist level, and 5 percent gained endorsement at the Reflective Practitioner II level. Among TMHP participants, 13 percent achieved endorsement at the Transdisciplinary Mental Health Practitioner level.

Conclusion

Both individual and final survey responses from the Foundations of Infant-Family and Early Childhood Mental Health Training Program show strong evidence of the value of the training program. Figure 7 provides a concise illustration of the overall impact of the program on training participants. For example, 90.8 percentof participants agreed that they had learned more about early childhood mental health; more than 75 percent of the group agreed that they had increased or deepened their understanding of the importance of their work with infants, families, and young children.

Figure 7. Reported Benefits of IFECMH Participation



In terms of the program structure, the opportunities for collaboration through discussion of case studies and session topics afforded participants key benefits: new information and resources to share with families as well as multiple perspectives on IFEMCH professional practices. Participants cited the value of engaging in reflective practice and its benefit for their own engagement in the sometimes challenging work of serving high-risk children and families. Overall, findings from the training program strongly indicate that it positively influenced both knowledge and practice among Monterey County professionals serving infants, young children, and their families.

Appendix: Demonstrated Program Success: Participant Stories

As part of the final evaluation, participants were asked to respond to the following question, "Thinking about what you have learned, how has the content of the training series impacted your work?" Their responses reflect the breadth and depth of the impact of the IFECMH training program.

- *"I have begun to work with a mother of two children under age five that is currently experiencing lack of financial stability and support, history of drug abuse, domestic violence, and issues with the legal system. As a case manager, I am exploring with mother services in the community that can assist her with establishing protrective factors that could reduce the risks of abuse toward her children. This would include linking her to drug rehabilitation treatment, housing resource, and mental health services for herself. The article on "Parents as Abused Children" has been instrumental in helping me see this situation with a different lense."*
- *"The most important impact of the training in my work is the increased ability to stay reflective as I interact with the families in my work. I have noticed that I no longer take it personally when parents are not accepting of resources offered to them — this seems to also have increased my joy and satisfaction when the most simple suggestion or encouragement seems to enrich relationships between parents and their children. Ex. A parent who could not be open to use support with her only child, insisted that she did not have the time to invest in parenting classes. "That is not for me," Mom stated. On the other hand, a family whose parents speak an indigenous language and do not know how to read and write were very happy to hear about resources such as the reading programs for young children at the library, because they could take their baby and toddler and have them experience book reading. These parents were surprised to hear how meaningful and valuable what they are doing for their children is (spending relaxed time on the floor with them, singing in their native tongue, having routines, trusting their rhythm and a few more concepts that I could explain to them due to the understanding I have managed to fine-tune by attending the IFECMH). They walked away beaming with pride."*
- *"I am working with a 4 year old girl brought in by her mother for anxiety. After developmental assessment it was noted the child has significant sensory issues, some neuro-social learning differences as well as a significant family history of mental health issues including a teenage brother recently hospitalized for suicidality. I provide attachment-based family therapy, including dyadic sessions with the father to assist in engagement, referred the child to an occupational therapist, linked the family to play group, provided education regarding ASD, and referred the child for complete assessment. "*

- *"Toddler age 18 months to 2.6 years received care and observations were made using the tool ASQ at differing stages of development. My observations and ASQ ratings concluded that the child was falling below in areas of fine and gross motor skills as well as communication. After these findings the child was referred to the San Andreas Regional Center for further testing and received services. The child's family participate in the Seasonal Migrant Head Start program and have chosen to stay and work in southern CA in the Riverside area. The family has kept contact and shared their decision to stay in the Riverside area to get family support for their child. I feel that the ongoing open communication with the child's family and the sharing of the ASQ tool as well as information gained in the Mental Health Trainings gave the family the support and allowed them to trust that I was qualified to provide the resources needed for their child. Their sharing of their family's decision informed me that they had their child's best interest in mind and that they felt it was important to seek extended family support for their child."*
- *"When talking about the different types of attachment, and sharing with the group about some of the children in my program, I was able to understand and recognize the type of attachment disorders they were displaying. This enabled us to provide more appropriate support for the child and family."*
- *"Everything I learned in the institute has helped me to become a better supervisor for my staff. I have been practicing Reflective Supervision for the last 12 years with my home visitors, but coming to these trainings and having experienced Reflective Supervision done on me has helped me understand even more the value of actively practicing it with my staff."*
- *"There are many children who come to clinic for well child visits whose parents do not want them vaccinated. In these instances, verbal and written information regarding risk versus benefits are routinely given to parents, but they almost always never change their decisions. I met a well-educated family whose second child (a small infant) was due for vaccines but the mother angrily refused any discussions or reading materials that I offered. Normally, I would pause, respectfully acknowledge their views and efficiently move on to the next part of the visit. However, her unusual degree of anger made me stop, rather than just pause. Thinking on my feet, I thought that this might be a good time to apply some reflective practice that I have learned from my IFECMH training. I consciously stepped out of myself and rearranged the scenario in front of me; I focused my entire being on this family: the mother's words, her tone, the tight way she was holding the baby, the baby's cry of discomfort, the father's quiet embarrassment, the peculiar older child's inattention. I pictured my active self standing in front of them, eyes, ears, mind and heart, wide open, ready to receive. I pictured my silent self watching over this room of people, their movements, words, thoughts and feelings. I quietly asked the parents what, why, where, and how come they have these concerns, and gave them as much time as they needed to answer. They were honest; initially, full of conviction, then later, full of worry and concern, and then lastly, full of doubt. It did not take*

long to gather all the information I needed although it would have seemed so. In fact, everything I learned in those few minutes was more relevant and critical for the baby's visit than all the answers to the routine questions I normally would have asked. It was a complex family, as most of my families are; mother was a foster child, father was a substance user, the older child is developmentally delayed, the baby was prematurely born with complex medical problems. And yes, they wanted vaccines for the baby. "

- *"The training "What We Need to Know About Child Health and Disability" on March 12 really impacted me. I have a little boy in my classroom who has a facial disability as well as a tracheostomy. The children would stare at him and leave him out of their play. This of course concerned his mother so the other two teachers and I met with mom to listen to her concerns about how her son was being treated. We were able to reassure the mother and let her know that we would be having several lessons with the children in our class about being different. We continued these lessons for several weeks, modeling and reading stories about various differences in others. The children finally became comfortable around our child and his disabilities and included him in their play. The mother who was always in the classroom observing the interactions of the students and her child is so comfortable now that she has started a job! The training and the suggestions from my group showed me different ways to engage and support this mother."*
- *"In one family that I worked with, the mother was having difficulties connecting with and learning to read the cues, behaviors, and cries of her 9-month-old infant. I worked with mother by reviewing a booklet that showed how she can interact, play with her child to engage connection, learn reciprocal interaction, read body cues, etc. Also discussed mother's level of self-regulation and its importance and how mother's self-regulation can be transmitted to her child, and in turn her child would learn self-regulation by their connection with each other. I also discussed the importance of holding her baby while feeding, the eye gaze and its importance, and attending to her crying baby to develop secure attachment and learn to trust. I also reviewed how brain development is dependent on mother's/caregiver's empathic, loving, respectful connection and response to her child. I also encouraged mother to gauge her interactions, so as not to overwhelm or overstimulate the child, who had not developed abilities to say no and set boundaries. This mother gradually learned 1) to apply age-appropriate play activities with her child, 2) to provide a positive learning environment for her child by offering learning opportunities for the child to explore, 3) Mother was responsive in attending to her child's unspoken body language, 4) Mother learned to self-regulate her own emotions by seeking support, giving time out, asking for help, to contain her own stress levels and to respond appropriately to her child."*
- *"I was able to recognize when young parents were being negatively pigeonholed about their behavior towards the staff and what appeared to be the lack of attachment to their baby. They themselves had very traumatic childhoods, which was affecting the way they were now*

handling the crisis at hand. I understood that during this crisis the parents were being re-traumatized. Their childhood trauma was now influencing their behavior. From my training I was able to share with the team a different perspective on this young couple. I was able to connect this young family with the appropriate agency so that they could get their mental health needs addressed. By connecting them to the right agency that would support them as they faced their own issue, along with reflecting on parenthood, I really think I was able to prevent even more trauma than they were already experiencing."

- *"As I reflect and think about how this material has impacted my work I can think of one example. I do home visiting and often my families have been referred by DSES. I have one family in which the child (a toddler) was traumatized by prenatal substance exposure and who experienced domestic violence. As a result, he has serious delays in development, and his behavior has been very dysregulated. Over time I have supported his mother in appropriate parenting skills and she has had the benefit of other interventions as well (Circle of Security class, PPP, therapy). As the case ran its course, the time came to make a recommendation, and it appeared that the court system was going to recommend against reunification. Because of what I have learned in this series, I felt that I was able to advocate for her effectively (as well as other partners), and this made a difference in the final outcome of her case. The child was recently reunified with his mother and they will continue to receive supportive services."*
- *"In participating in the training I have been able to be more reflective in my approach to families. I can state that the training played a role when I was working with a family who lost custody of all their children due to child abuse. The mother became pregnant again with her sixth child. In a home visit she was discussing her need for income from DSES and how the new baby was her opportunity to accomplish that. I can state that I revisited what I learned from my facilitators in the small reflective group, which allowed me to halt my immediate reaction to judge the mother for her words and action. I stopped myself in projecting my own personal values and what I though was right, In turn, I allowed her to speak and I learned from her what was the root to her logic and comments. This allowed me to be more effective in working with the mother versus being judgmental because of her past history. I learned that I needed to work with her collaboratively to be helpful on her new journey with her new child."*
- *"I have included parents more in working with children 5 years old and younger. With one family, I have requested the parents be more involved in the play sessions and have noticed more opportunities have occurred for parenting changes. The parents are understanding the child's behavior more as a need versus attempts to bother the parent."*
- *"I am currently working with a family going through the SARC IFSP process. I have been pushing for the child to be evaluated for a long time as there were many hurtles to cross. The last IFECMH training focused on the family's perspective on children with disabilities and all*

that parents go through when realizing their child might need services. This training made me realize I have been so focused on getting the child services that I have neglected to shed light on the parents and their experience and feelings throughout the process. Last week I met with them and the discussion focused on them. They appreciated that I took a step back to talk about their needs and how we can work to find them the support they also need through this process."

- *"The session in which we covered fatherhood increased my awareness of how we engage fathers within our agency when meeting with families in their home. In visits following this I've been more intentional about the way I include a father in visits/meetings. You can see how it catches fathers off-guard when you ask for their take or wonder with them if they'd like to be included in the discussion. So much more information has been gained from giving them this opportunity. In one case specifically, we learned that many of the mother's worries in father's eyes "made sense" (i.e., child jumping on bed) because others in the family do this and he did this as child. His voicing this opened a dialogue to connecting more deeply with them both and supporting them in their co-parenting."*

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