



The Douglas County Infant Mental Health Project (DC-IMH): A Place-Based Professional Cohort Model

A Guide for Rural Communities Seeking to
Build Infant Mental Health Collaborative Projects

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The Douglas County Infant Mental Health Collaboration

Funded by The Ford Family Foundation



What began as a dream became an idea. The idea became a plan and, eventually, the plan became action. In January of 2019, The Ford Family Foundation and Portland State University launched a joint project with the goal of strengthening and connecting the support systems for young children and their families in Douglas County, Oregon.

Douglas County is a rural region located in southwestern Oregon. Roseburg, the county seat, is at the center of the picturesque Hundred Valleys of the Umpqua. The Umpqua River, which gives the region its name, meanders for 111 miles through valleys and mountains before emptying into the Pacific. The community is nestled in a lush, forested region approximately an hour from Eugene to the north (home to the University of Oregon) and Medford and Ashland to the south. The entire region is known for its hiking and fishing. Roseburg, with a population of approximately 24,000, anchors Douglas County, which is about the size of the state of Connecticut with a population of approximately 110,000 people. It is an area that hosts a diverse population with a variety of strengths and needs.

This project is located on the traditional homelands of the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians, the Coquille Indian Tribe, the Cow Creek Band of Umpqua Tribe of Indians, and the Confederated Tribes of Grande Ronde. We acknowledge the ancestors of this place and understand that we are here because of the sacrifices forced upon them. By recognizing these communities, we honor their legacy, their lives, and their descendants.

We would like to acknowledge the support and work of the following individuals and institutions that make this project a success.

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***“There is no power for change greater than
a community discovering what it cares about.”***

Margaret J. Wheatley

This book is dedicated to the pioneers in mental health. This includes individuals and groups that created the policies already written, billing codes, diagnostic crosswalks, and those who have worked tirelessly to reduce the stigmatization around seeking mental health services. The participants wish to acknowledge that an unpayable debt of gratitude is owed to those that have come before them who knew the incredible impact of infant and toddler mental health.

This book is also dedicated to the individuals just beginning this journey. This work will always be relevant. It is a solid time investment to begin this journey now.

The work is hard, but the rewards are big.



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Executive Summary



"The field of infant mental health is defined as 'multi-disciplinary approaches to enhancing the social and emotional competence of infants in their biological, relationship, and cultural contexts.' "

***Charles Zeanah and Paula Zeanah,
Aug./Sept. 2001 Zero to Three***

In Douglas County and in other areas of rural Oregon, there is a significant need as well as a growing interest in infant mental health, which refers to the social and emotional development of infants and toddlers in the first three years of life.ⁱ During those years, young children's development is guided by their primary caregivers, parents and others who spend significant amounts of time with them. Brain development in this critical time period affects all areas of growth – physically, cognitively, socially, emotionally and linguistically. That is why experiences in the first three years of life are critical building blocks for future development.

Young children need healthy attachment to primary caregivers in nurturing environments for healthy development. With young children's absolute dependence on their caregivers, infant mental health considers the health and well-being of both the child and the primary caregivers as intertwined. Using strengths-based practices, infant mental health supports the building of strong dyadic (one adult/one child) relationships that are the foundation of healthy attachment and relationships. Attention to infant mental health helps the family unit and primary caregivers support young children's relationships by addressing social and emotional stressors that impact development and the wiring of the brain in young children, 0-3 years of age.

Infant mental health is designed to strengthen protective factors in a community, including:

- Enhancing parental resilience to meet challenges and demands.
- Providing an array of social connections to mitigate isolation.
- Giving parents coordinated and specific supports in times of need.
- Facilitating knowledge of parenting and child development.
- Supporting healthy social and emotional development in young children.

Infant mental health supports emerge from interdisciplinary practices that involve families, social services, health, law enforcement and education to support families and caregivers of children neonatal to 3 years old. Supporting infant mental health offers unique opportunities to build on coordinated care systems for families and their young children in the community across public and private agencies.

The Douglas County-Infant Mental Health Project was a place-based professional cohort model. It focused on providing opportunities to support coordinated services between agencies while addressing issues of shared language and coordinated delivery of services for families and caregivers of children neonatal to three years of age. All of these activities were based on a shared understanding of research-based infant mental health. The project's goal was to create a safety net to support vulnerable families who had difficulty finding and/or accessing resources through coordinated services.

A multi-pronged approach was taken to support the Douglas County community in developing its own structures and norms within a foundation of shared values. The approach focused on building an interdisciplinary cohort of individuals and agencies to serve children 0-3 and their families that were engaged in strategic activities, including:

- A shared educational research foundation in prenatal to 3 years – Portland State University's Infant/Toddler Mental Health graduate certificate.
- A shared demonstration of competencies – Infant Mental Health Endorsement® requiring a portfolio and exam.
- A shared ongoing reflection on practice – reflective supervision.
- A shared ongoing construction of interdisciplinary approaches – networking and on-going professional development.
- A shared input in designing a replicable model for other rural counties.

Lessons Learned

Lesson 1: Relational work is important in rural communities. Building relationships need to take place over time, both as a primary and ongoing focus of the rural infant mental health work.

Lesson 2: Both interdisciplinary and multidisciplinary practices need to be developed. Working towards a multidisciplinary coordinated system of care for diverse rural communities required mapping of individual and organizational connections. Activities reveal both strengths of connections and silos of organizational information or bias based on narratives of competing resources.

Lesson 3: Strong place-based work acknowledges the complex relationships in rural communities. Projects need both leadership in the community and external supports to address issues of transparency between agencies to mitigate issues of perceived organizational power or preference.

Lesson 4: Sustained and transparent coordination is required for systems change. A project needs to develop a unified understanding of the group's goals. It is important to slow down to allow the process to unfold. Historic beliefs about individuals and communities require time to re-orient to build trust and new understandings.

The Guide



Each baby is born into a unique family that has its own culture and history, its own strengths, and its own way of coping with stress and adversity.

Parlakian & Seibel, 2002ⁱⁱ

Introduction

Infant mental health describes the practices that support children's social and emotional development from birth to 3 years old. It is the key to responsive caregiving that supports both families and early childhood professionals as they guide the development of healthy social and emotional behaviors in young children.

Infant mental health refers to how well children develop socially and emotionally from birth to age 3 years. This includes their capacity to express and regulate their emotions, begin to form relationships, and explore their environment. In the first three years of life, young children's development is guided by their primary caregivers, parents, and others who spend significant amounts of time caring for them. Since young children's brains wire their development – physically, cognitively, socially, emotionally and linguistically – experiences in the first three years of life are critical building blocks for future development. Young children need healthy attachment to primary caregivers in nurturing environments for healthy development. Using strengths-based practices, infant mental health supports the building of strong and healthy dyadic (one adult/one child) relationships.

Helpful Terms

Dyadic Relationship – The one-to-one relationship between a child and a primary caregiver that supports healthy attachment and development.

Caregivers – All individuals including parents, extended family (such as grandparents) and early childhood educators who care for an infant or toddler on a regular basis.

Infants – The period from birth to 18 months.

Mental Health – “Mental health reflects ‘our emotional, psychological, and social well-being.’ Affecting ‘how we think, feel, and act,’ mental health has a strong impact on the way we interact with others, handle problems, and make decisions.”ⁱⁱⁱ

Mental Illness – A wide range of conditions and disorders that affect an individual’s behavior, mood, and thinking. The diagnosis of a mental disorder is done by a mental health professional and meets specific criteria using a common diagnostic tool.^{iv}

Infant Mental Health (IMH) – “The developing capacity of the child from birth to five years of age to: form close and secure adult and peer relationships, experience, manage and express a full range of emotions, and explore the environment and learn - all in the context of family, community and culture.”^v

Infant/Toddler Mental Health (ITMH) – Term used by Portland State University to delimitate the 20-graduate credit program.

Interdisciplinary Infant Mental Health – Interdisciplinary practices that involve families, social services, health, law enforcement, and education to support families and caregivers of children neonatal to 3 years of age, providing a coordinated safety net for young children and their families.

Primary Caregivers – Individuals who spend significant time in the primary care of the child. The child has one or more primary caregivers who takes care of the child’s physical, emotional, social, cognitive, and linguistic needs.

Prenatal – Development of the child prior to birth.

Reflective Supervision – A competency-based professional development and administrative supervision parallel process focused on the importance of relationships. Attention to all of the relationships is important, including the relationships between practitioner and supervisor, between practitioner and parent, and between parent and infant/toddler.^{vi}

Toddlers – The period from 18 months to 3 years old.

Using the Guide

List of guidelines

- Dedication to a multi-professional-based approach to infant mental health.
- Commitment to quarterly networking and professional development meetings.
- Desire to increase relationships with individuals and agencies.
- Appreciation of the many diverse family structures found in the community.
- Consideration of key principles and recommended practices when working with young children and their families.

How community leaders can use the guide to build IMH cross-sector collaborations	How cross-sector members can use the guide to inform their work individually and collectively
<ul style="list-style-type: none">• Recruit and support a diverse set of participants that represent a variety of agencies supporting young children and their families.• Plan quarterly networking and professional development meetings to build community and work towards future community goals.• Consider areas of strengths and areas that need further support for cohort professional development opportunities.• Recognize and celebrate their own strengths in terms of their reflective capacity and ability to provide reflective supervision.• Support the cohort in understanding and addressing personal bias around young children and their families.• Collaborate with participants to consider key principles and recommended practices when working with young children and their families.• Facilitate reflective supervision sessions.	<ul style="list-style-type: none">• Work towards establishing reciprocal and respectful relationships with other members of the cohort.• Actively participate in the quarterly network and professional development meetings to build community and work towards future community goals with cohort members.• Recognize and celebrate their own strengths in terms of their reflective practice capacity and ability to support reflection in the young children and families with whom they work.• Seek to understand and address their personal bias around young children and their families, including the areas of race, nationality, citizenship status, socio-economic status, family structure, and gender identity.• Consider key principles and recommended practices when working with young children and their families.• Actively engage and participate in all course readings, interactions, and assignments.

Strengths-Based Approaches

The strengths-based approach moves the focus away from deficits of people with mental illnesses and focuses on their strengths and resources. It builds relationships with and among families that support children's development, family well-being, and positive parent-child interactions.

- Families are engaged in meaningful and culturally respectful ways and have opportunities to influence programs, practices, policies, and systems for young children.
- Every family is seen as having unique skills that can contribute to family success.
- Care providers identify and build on family strengths for supports.

The strengths-based practice is a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets. As such, it concerns itself principally with the quality of the relationship that develops between those providing and being supported, as well as the elements that the person seeking support brings to the process.^{vii} Working in a collaborative way promotes the opportunity for individuals to be co-producers of services and support rather than solely consumers of those services.^{viii}

In a strengths-based approach, everyone is a teacher and a learner. Everyone has something to contribute and everyone can learn. Rather than being the expert, facilitators recognize the expertise of participants and are open to learning as well.

It means that we actively involve participants in decisions about the purpose, content, and processes of designing supports. Strengths-based groups are unlikely to run to a set curriculum with a pre-determined outcome. Because we recognize the strengths and expertise of participants, the group often plays an important role in shaping what happens.

Dynamic Models of Development

Infant mental health focuses on the dynamic models of infant development by coming to understand that development is non-linear in the first eight years of life.

Dynamic systems theory addresses the *process* of change and development, rather than developmental *outcomes*; in dynamic systems terms, there is no end point of development^{ix} (Thelen & Ulrich, 1991). Moreover, with its central focus on change and change in the rate of change, dynamic systems theory points to questions about both (a) change from one time point to the next; and (b) overall patterns of change. Chief among the contributions of dynamic systems theory is a set of concepts facilitating examination of overall patterns of change. Such patterns include stabilization, destabilization, and self-regulation.^x

Dynamic models of development acknowledge that while children go through stages of development, there are influences on development that move it away from a linear process into one that is multi-faceted. Development advances in non-uniform directions based on environmental factors such as nutrients, sleep, and relationships, all impacting how the infant/toddler develops. This is different than applying developmental theory as the sole explanation of how a child moves from one milestone to another.

Dynamic models also focus on the intersection of how biology develops the brain and how the brain makes connections. We see that there are critical periods in a child's brain development. That is, the longer a child has been exposed to one type of experience or environment, the less likely he or she will be able to reverse the synaptic learning that has already taken place. That development occurs in windows of time.

There are certain times or critical periods that the brain is open to developing specific skills or traits. When responsive caregiving occurs, children receive what they need to develop. However, when a critical period is missed, it becomes much more difficult to develop the specific skill or trait. It is the difference between walking through an open door and pushing a 10,000 pound door open developmentally. – Ingrid Anderson

Understanding dynamic models of development helps to frame the critical importance of supporting families with young children. Early mental health supports for families help to build resilient family units by working with both young children and their primary caregivers.

Primary Caregivers

In today's society, many people can take on the role of a primary caregiver. The makeup of the family unit includes combinations of the following: one parent, both parents, family members such as grandparents, or designated legal guardians. All primary care includes food, shelter, comfort, cognitive stimulation, and emotional support. For the purpose of this guide, we define family as an "inclusive way to describe the realities and diversity of children's primary caregivers."

In the early years, children cannot manage their feelings on their own – they need parents and other caregivers to help them soothe, settle, and manage feelings. Infant mental health is centered on the whole child, and all areas and domains are influenced by others. Many aspects can affect a child's mental health. These aspects include early trauma, compromised development, biological changes, challenging relationships, at-risk environments, toxic stress, and other influences.^{xi}

Supporting Family Relationships

When attempting to implement change, whether it is systemic, social, or both, it can take numbers and data to get people to pay attention to the problem. Data and numbers motivate action. In the 2020 State of Babies Yearbook put out by *Zero to Three*,^{xii} the data shows that children living with families that were considered low income were less likely to have access to prenatal maternal care, high quality early learning experiences, and to be read to daily by a parent or caregiver. Additionally, children living with families that were considered low income were more likely to live in neighborhoods that parents considered unsafe, experience housing instability, and be exposed to more traumatic events.

When advocating for systematic and/or social change, what moves individuals from just taking notice to actively working towards becoming involved in creating change are stories. Stories connect us. We see ourselves and the people we care about in the stories that others share about their experiences. We connect with the struggles, and become inspired with the successes.

Relationships are essential for infant mental health practices. When families seek out or are required to get support, they are often in extremely stressful situations. This stress can lead families to feel highly suspicious, and building trust can be difficult. Once trust between an individual and family has been established, individuals that work in the mental health and family support fields may not feel comfortable referring families to other services based on uncertainty of how the agency works or unsatisfactory past experiences. Therefore, a trusting relationship with other supporting agencies is critical to maximize services for families.

Establishing mental health and family support collaboratives within communities, especially rural communities, has multiple benefits. It allows for trusting relationships to be formed between agencies and individuals and helps build a stronger understanding of which agencies offer what services. Building mental health and family support collaboratives within communities help to create a system of trust in which families can feel comfortable seeking out the services they need, not just from an agency but from an individual who has been recommended by someone with whom they already have a trusting relationship established.

The Case for Early Childhood Mental Health Support

Mental health is a positive term that refers to the presence of mental or emotional wellness and the absence of mental illness. ^{xiii}

When one hears the phrase “infant mental health,” there may be a tendency to be concerned that it is connected with mental illness and be puzzled as to how the term could be associated with the stage of infancy and toddlerhood. What many may not realize is that infants can experience very strong emotions long before they have words to express what they are feeling.

It is critical to start mental health supports early which have their foundation in secure dyadic relationships between young children and their primary caregivers. Providing a solid foundation of social and emotional skills and a supportive living condition is important for all children. Youth ages 10-19 are experiencing many social, emotional, cognitive, language, and physical changes, further developing and maintaining social and emotional skills they acquired during early childhood. Skills such as making and maintaining friendships, showing empathy, regulating emotions, resolving conflict, and building resiliency are as important during the early years as they are in adolescence and in adulthood. These skills allow young children, as well as adolescents, to develop their sense of self and self-identity.

Young children are completely dependent on the care and decisions of others for protection, food, shelter, and their safety. This creates greater risk for exposure to stress, abuse, and trauma.^{xiv} Each child’s exposure to risk or development resiliency is based on the complex network of factors at the family, community, and societal levels. Access and/or utilization of supports impact healthy attachment or social and emotional, cognitive, language, or physical development. Risk factors may be associated with the mental health of parents, food, or housing insecurity, and/or domestic violence. Risk factors create stress in a young child’s development, thus affecting how relationships are formed and how the brain is wired. Resiliency refers to individual and environmental protective factors, including health, mental health, nutrition, family supports, early care and education, and specialized services.

Early mental health supports start with:

- Recognizing social and emotional development and health of young children.
- Supporting parents and caregivers in developing secure attachment through the dyadic relationship (one adult-one child).
- Interpreting children's behaviors correctly and identify supports along the mental health continuum.
- Identifying the unmet needs that lead to children's behaviors, identifying risks and resiliency in each child.
- Constructing relationships with families that honor each family's unique strengths and culture.
- Developing a comprehensive systems of referrals that match families to culturally responsive services.

All professionals that work with young children and their families must understand the importance of supporting children's early mental health from infancy. Across Oregon, there remain shortages of agencies and professionals to serve the specific needs of young children 0-3 years of age. Despite significant investments, demand continues to outpace available services. Rural communities have identified creative solutions to attempt to bring the gap.

Unfortunately, a cohesive understanding of early childhood mental health is not the case. Many professionals working with children and families only have a surface level of understanding about what infant mental health is or how to support it. These professionals include OB-GYNs, pediatricians, case workers, early childhood care and education providers, psychiatrists and child psychiatrists, first responders, and judges, among others. Even for those working with children and families who do understand infant mental health, the language, structures, and ideas can differ vastly from individual to individual. These disjointed approaches are neither synchronized between agencies nor offered through a mental health lens and can lead to confusion and misunderstanding for both support people and families.

Thus, there continues to be an urgent need to build capacity to serve rural communities. Current barriers include:

- A misunderstanding of concerning behaviors and the underlying unmet needs.
- Parents and school personnel having to navigate complex systems to medically diagnose children.
- Community health specialists that do not have sufficient training or education focused on the first three years of life, which impacts their capacity to serve young children and families.
- Medical homes (defined as medical services where individuals receive consistent care) that do not know how to utilize or bill under medical complexity codes that could support increased capacities and efficiency.

A coordinated system of infant mental health professionals can help address the gaps that exist in rural communities.

Infant Mental Health Professionals

Infant mental health professionals come from many fields and hold many different roles.

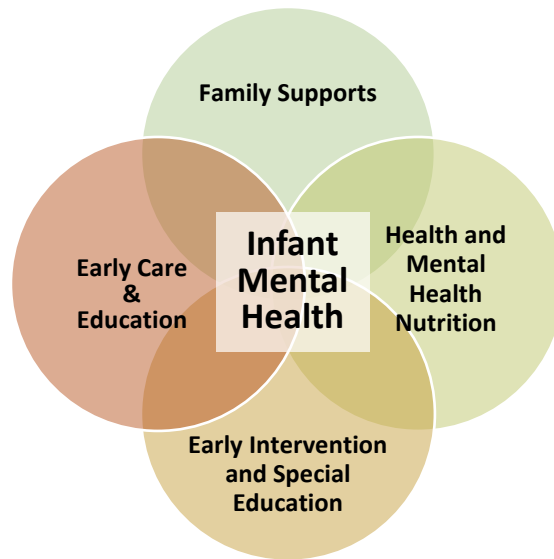


Figure 1: DC-IMH Roles

What IMH professionals have in common is a knowledge of risk and resiliency factors in families of young children, 0-3 years of age, with a strong foundation of social and emotional development. IMH includes areas like early screening and assessment, theories of treatment, home and community-based intervention, and the use of diagnostic classifications and tools.

Infant mental health professionals strengthen protective factors in a community, including:

- Enhancing parental resilience to meet challenges and demands.
- Providing an array of social connections to mitigate isolation.
- Providing parents with coordinated and specific supports in times of need.
- Facilitating knowledge of parenting and child development.
- Supporting healthy social and emotional development in young children.

Infant mental health professionals provide supports during the critical first 1000 days of life.

The first 1000 days are a time of tremendous potential and enormous vulnerability. How well or poorly mothers and children are nourished and cared for during this time has a profound impact on a child's ability to grow, learn, and thrive. Research in the fields of neuroscience, biology, and early childhood development provide powerful insights into how nutrition, relationships, and environments in the 1000 days between a woman's pregnancy and a child's second birthday shape future outcomes. At every stage during the first 1000-day window, a child's rapidly developing brain is vulnerable to poor nutrition, neglect, and the "toxic stress" that comes along with hunger and food insecurity.^{xv}

Supporting mothers and babies during the first 1000 days through mental health support, access to safe housing, nutrition, and protection from violence and toxic stress is the best way to ensure that children are on a pathway towards a happy and healthy future.

Resilient professionals are needed to support families. Research shows that infants, toddlers, and their families experience higher risk factors in rural areas, and infant mental health professionals encounter barriers for professional development.^{xvi} Addressing the needs of families and professionals requires an understanding of the unique strengths and challenges in rural communities.

Culture of Rural Living

Rural Oregon is filled with vibrant communities. Rural communities have strengths and knowledge to address issues and create solutions that are as unique as they are. Rural community mobilization draws from its strong foundation of relationships that are both multifaceted and interwoven. Everybody knows, or at least knows of, everybody else. Your neighbor may be your child's fourth-grade teacher, the pharmacy store clerk, your spouse's best friend, or your pastor and/or your child's soccer coach.

Rural communities also face obstacles in access to opportunities that support and enable their success.^{xvii} The dynamic of social interactions in rural communities can be both embracing and isolating. Research shows that investments that harness the power of community build on values of self-empowerment and resilience that are highly valued in rural areas in Oregon.

One of the greatest assets in rural communities is that often, generations have lived here, and people share multiple circles that they run in. There are multiple points of connection and spheres of influence, which definitely strengthens the community.^{xviii}

Each rural community is different and understanding the strengths of each one is foundational to building and sustaining capacity. Identifying resources, opportunities, and challenges offers community members the ability to self-identify their strengths and opportunities. Working collaboratively, rural community groups understand the complexities of the unwritten but enacted values of self-sufficiency, independence, and autonomy that can create tension in collaborative partnerships across communities of practice or service providers.

Oregon's vibrant rural communities are found in every county. While each county is unique, there are some shared commonalities that impact family and community support. Women living in rural communities have decreased access to prenatal, natal, OB-GYN, and postnatal care and may be geographically distant from their peers.^{xix} Geographical distance issues increase a woman's childcare and household responsibilities and can limit their social interactions with friends. Women in rural areas are twice as likely as men to suffer from depression. Access to medical services can be difficult due to a lack of availability or specialization, transportation issues, or the inability to pay for services.

Supporting the mental health of children and families is essential for a community to thrive. Although the number of individuals, agencies, and support systems in which families can seek out mental health support is increasing, children and families may have difficulty obtaining access or

finding the services they need. The complications of this issue may be multiplied in rural communities. The main obstacles for mental health treatment in rural areas are seen as being accessibility, availability, acceptability, affordability, and stigma.^{xx}

Mental health supports are even more difficult for children to receive in rural counties.^{xxi} Infrastructure support may be under-resourced (funding or personnel). The tension between demand and capacity impacts both individuals and agencies alike. Finding balance between promoting mental support and having the capacity to support demands can impact both advocacy and perception of value of inaccessible services. Further, there remains stigma associated with mental health across all demographics, rural and urban alike.

Importance of Reflective Supervision in Rural Communities

One of the issues often experienced in rural communities is the narrative developed about each agency by the participating organizations. There can be the need to break down past organizational and individual histories of community members in order to both rebuild and develop trust. Through a slow and thoughtful process of developing ground rules and establishing safety, community members can begin to connect with each other as individuals with shared systemic barriers and personal passion for working with families. Another issue experienced in both rural and urban areas is the creation of information silos. Reflective supervision increases the opportunity for members to develop individual contacts through sharing social connections and knowledge of existing programs, thus further breaking down existing information barriers and presumptions of groups.

While the term “reflective supervision” can be used in many contexts, the definition used for the purpose of this program comes from the field of infant mental health. IMH reflective supervision consultation focuses on a parallel process between reflective supervisor and the individual or group engaged in the process. It is a “distinctive form of competency-based professional development that is provided to multidisciplinary practitioners working in the infant/family field on behalf of very young children’s primary caregiving relationships.”^{xxii}

The intention of IMH reflective supervision is to foster collaborative relationships that help to sustain resiliency in the complex emotional work of IMH. That work can be defined as:

A collaborative relationship for professional growth that improves practice by cherishing strengths and partnering around vulnerabilities to generate growth. Through this way of being, a holding environment is created – an emotional breathing space – where it is safe to explore accomplishments, insecurities, mistakes, questions, and different approaches to working with young children and their families.^{xxiii}

Reflective supervision offers a form of self-care promotion that is necessary to minimize the frequent transitions and turnover prominent in the social services field, and to hold both professionals and families during this difficult but rewarding work.

Endorsement

Infant Mental Health Endorsement® intends to recognize and document the development of infant and family professionals within an organized system of culturally sensitive, relationship-

based, infant mental health learning, and work experiences. Endorsement® verifies an applicant has attained a level of education, participated in specialized in-service training, worked with guidance from mentors or supervisors, and acquired knowledge to promote the delivery of high quality, culturally sensitive, relationship-focused services to infants, toddlers, parents, other caregivers, and families. It is multidisciplinary and does not constitute a license to practice a particular profession.

The Infant Mental Health Endorsement® (also known simply as Endorsement®) was developed by the Michigan Association for Infant Mental Health (MI-AIMH) and is currently adopted in 30 U.S. states as a competency-based measurement of education, experience, and reflective practices.

The goal of Endorsement® is to create a shared framework that helps guide the development of early childhood mental health knowledge, skills, and best practices, gained through experiences such as education, work, in-service trainings and reflective supervision.

Endorsement® recognizes an individual's effort to specialize in the promotion and/or practice of infant mental health within his or her own chosen discipline. There are four categories of Endorsement® that relate to different skills and fields that make up IMH interdisciplinary structure.

These include:

- Infant Family Associate
- Infant Family Specialist
- Infant Mental Health Specialist
- Infant Mental Health Mentor (Clinical, Research/Faculty, Policy)

Endorsement® highlights a combination of education and work experience within the field of infant toddler mental health and pregnant mothers. Some categories of Endorsement® require the individual to receive and/or give reflective supervision (which was a secondary reinforcer of the inclusion of reflective supervision within this cohort experience). While Endorsement® is not a license, it allows professionals to identify themselves as having specialty knowledge, training, and experience within the field

The Research Behind the Guide

This guide was created as a manual following the success of a place-based professional cohort model in Douglas County, Oregon. The qualitative methodological approach in this collaborative project drew on the community-based participatory research model. Participants engaged in the refining of questions and study design, the collection and analysis of data, and the creation of solutions concerning their work. The study used phenomenological and interpretive methodology in which the lived experiences and perspectives of the participants are valued to better understand how they might harness and develop their professional capacities.

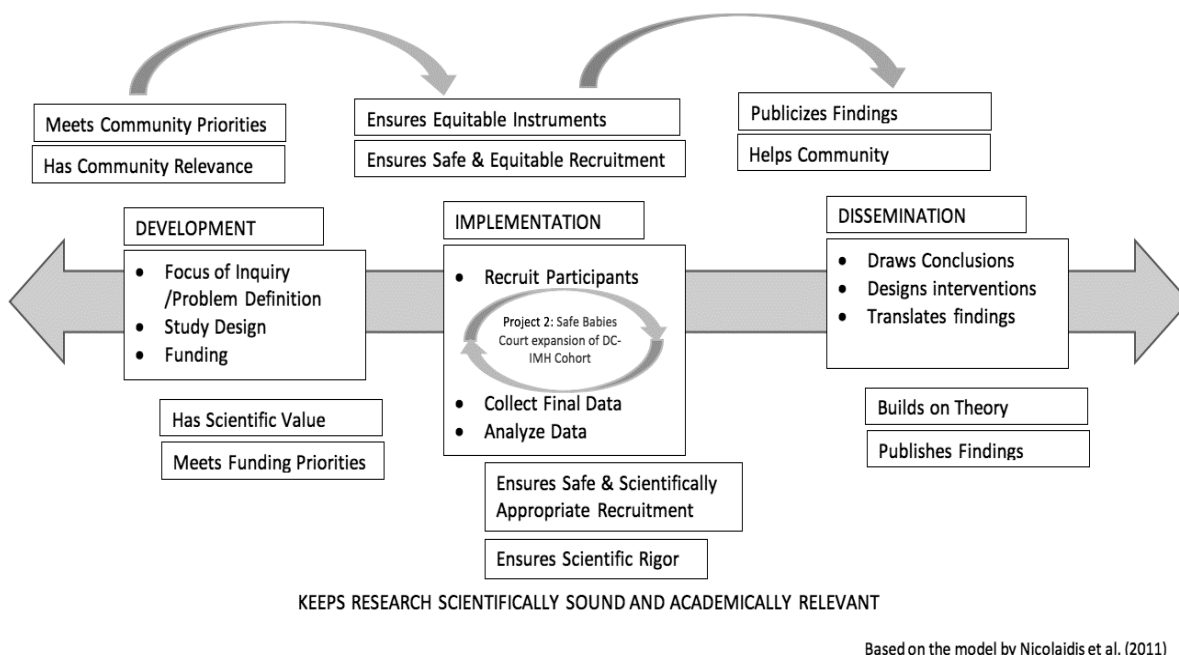


Figure 2: DC-IMH Community Participatory Research Model

The purpose of this research was to follow the participants and to amplify their voices about this experience. The mentor team was available to support the participants as a community and to understand how this project helped the participants learn and come to work together.

Participants were supported to engage in the refinement of questions and study design, the collection and analysis of data, and the creation of solutions concerning their work. While the findings were descriptive, the study also sought to illuminate “meanings” in the work of the participants and to use this data to propose actions that can support their professional development.

Research questions included:

- What are the characteristics of an infant mental health coordinated service model in Douglas County?
- What partnerships are needed to create a coordinated approach to services across public and private agencies?
- How can effective partnerships be developed, enhanced, and sustained?
- How might what we learn be transferred to other rural communities?

This guide seeks to share the findings from the research questions.

Key Concepts Emerging from the Research

Almost one in five people live in rural communities across the United States. The four key principles of the DC-IMH project focused on meeting the specific needs of rural communities by building pathways with these attributes, designed to be culturally sensitive to rural community needs:

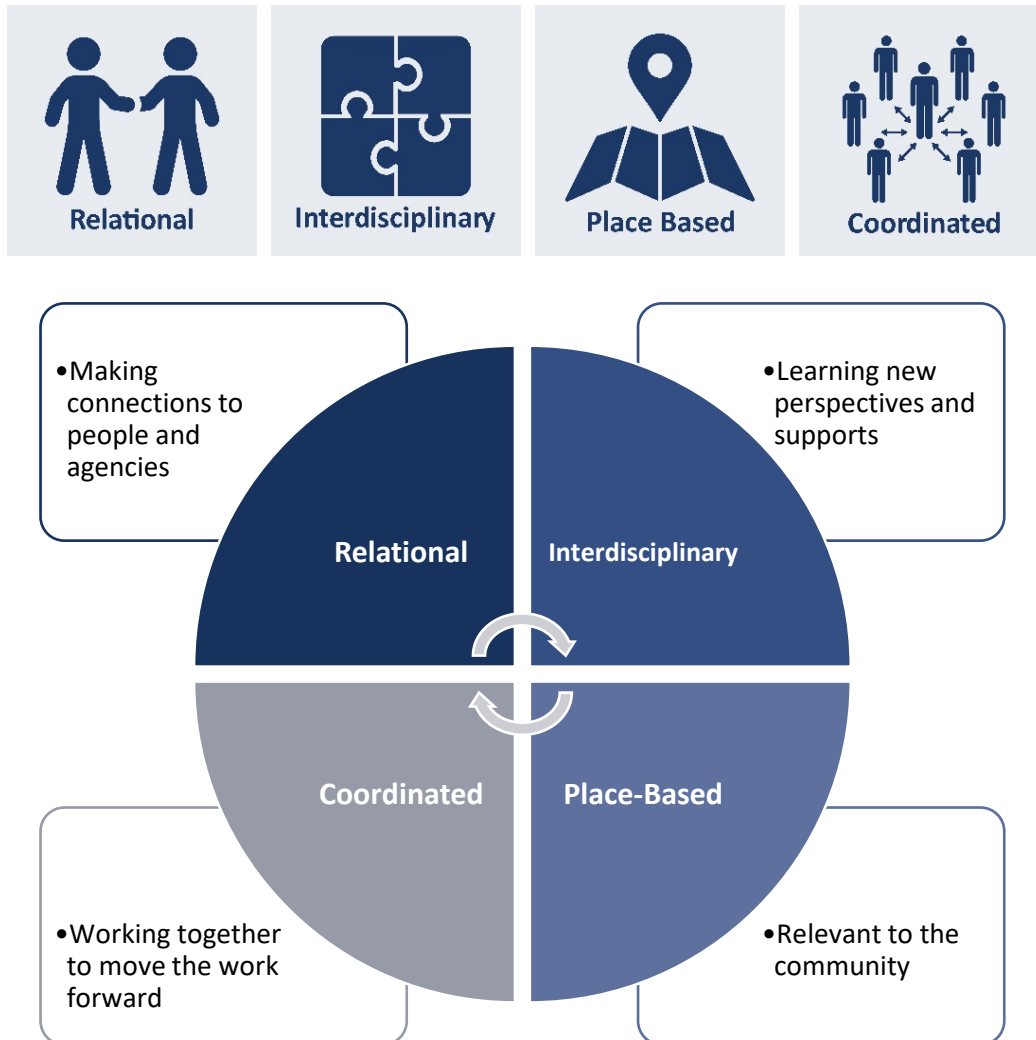


Figure 3: DC-IMH Four Key Principles

Relational Work

An overarching goal of this work is to create and sustain networks of relationships. Strong relational networks provide a safety net for both service providers and families. For service providers, strong relational networks create a coordinated system of infant mental health that supports building on services rather than duplication of services. Further, coordinated services help service providers to identify and predict trends and patterns of need and respond proactively in a community. Coordinated services help families to build their resiliency and minimize disruption in their lives. Coordinated services can streamline application to supports that mitigate emotional stressors on families.

Relationships are co-constructed over time. In the relational section of the guide, you will find information on developing collaborative relationships. Reflective supervision can serve as a strong support to build an interdisciplinary community addressing tensions that can arise as agencies work to coordinate and not compete for services.

Interdisciplinary and Multidisciplinary Practices

Successful relational work builds on two components. First, interdisciplinary approaches to supporting families and extending services build on both the unique knowledge of each individual and their fields of expertise to offer new understandings of complex issues and find innovation solutions. Second, teams find success in innovative approaches when they are multidisciplinary and come from the broad spectrum of agencies that serve families. Supporting infant mental health includes a cross section of expertise from early care and education, family supports, health, mental health and nutrition, early intervention, and justice. They all work together to create a comprehensive care system that is culturally responsive and meets the diverse needs of its rural communities.

Coordinated approaches take shared visioning to create the development of infant mental health systems within existing early childhood and family support systems. In this section of the guide, you will find information on activities that help groups to vision their coordinated efforts.

Place-Based Work

Infant mental health benefits from place-based approaches that support families' diverse needs in rural communities. Strong place-based work acknowledges the complex relationships in rural communities. It builds cross-sector expertise by creating both shared experiences and shared knowledge. It partners with funders and makes strategic investments to build capacity in infant mental health.

Examples of place-based work are provided in the guide. Strong place-based work acknowledges that partnerships evolve over time and existing partnership may break ties even as new partners and partnerships join to coordinate efforts. Part of the strategic planning process includes processes for the reconfiguration of partners and partnerships over time.

Coordination

Successful efforts to create sustained change require coordinated efforts. External coordination in rural communities can benefit from third-party agency or personnel. External coordination supports transparency between agencies and helps to mitigate issues of perceived organizational power or preference that can exist in cross-sector work.

Sharing the Douglas County IMH Story



The graduate certificate on its own was wonderful. The classes were relevant and applicable to, I think, rural areas as well as metropolitan areas and everywhere in between. However, the cohort magnified its efficacy a hundred times. Because what we were able to do was create these lasting bonds in a multi-disciplinary team setting to where what we've really done is reduce barriers to care for a lot of families in our community. Because instead of having to navigate different processes and guessing how to navigate to get into certain resources, it's now just a phone call. It's kind of giving our clients and ourselves some hope that we can access things, we can do what we need. And it's not going to be as complicated as it once was because of the collaboration that was fostered through this program.

DC-IMH participant

This guide was developed to share one rural community's stories and the actions they took to strengthen their coordinated network of agencies to support children 0-3 years of age and their families. It reflects the efforts of a community to develop a shared knowledge base, terminology, and skill set to address the complex issues that arise in rural communities and in all communities where resources for services cannot keep up with demand.

The cohort participants and mentor team share this story with you in the hope that as you walk alongside us, our goals, our successes, our struggles, and the ways in which we adapted and persisted, you will notice aspects that are similar to your own situation. You may see how to improve some of the areas in which we stumbled and you may be encouraged by the areas where we thrived. Overall, we hope that you will be inspired to create your own story, too.

The Douglas County Infant Mental Health Model

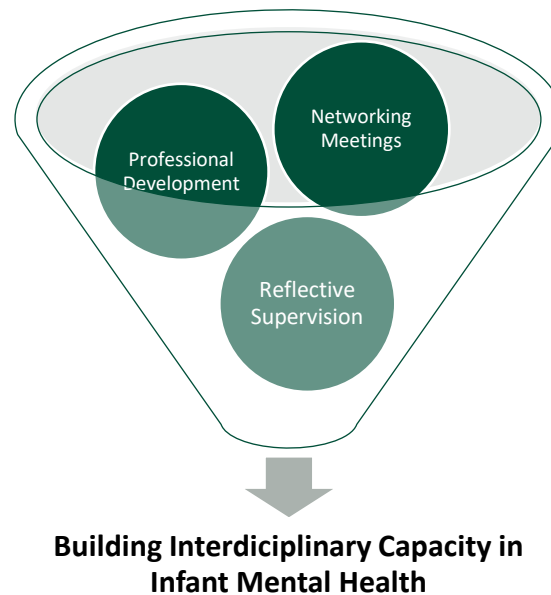


Figure 4: DC-IMH Model

The Douglas County Infant Mental Health project focused on a multi-tier model. Throughout each of the phases of the project, networking meetings, professional development, and reflective supervision occurred. Coordinating a multi-pronged approach supported individuals with diverse experiences from a cross-sector of professional agencies to come together to build a foundation for a coordinated system of infant mental health in Douglas County.

The project was designed to recognize that people who work in the helping professions can often feel isolated and disconnected, and burnout leading to turnover in these positions is often quite high. Research shows that skill development and emotional supports build resiliency in helping professions.

Networking Meetings

- Quarterly meetings focused on activities to build on interdisciplinary practices
- Serve as part of the participatory research model

Definition of Networking Meetings

Networking meetings are an essential component of a coordinated system of infant mental health. Networking meetings can be stand-alone meetings or identified within a subset of an existing meeting. However, networking meetings have three distinguishing factors:

1. Individuals meet for the purpose of forming relationships in their field(s).
2. Individuals and agencies work together in their local communities to serve people.
3. Individuals work internally and externally to form connections that look to facing future challenges, determining priorities, and building infant mental health supports.

Professional Development Activities

Professional development activities included:

- Completion of 20-credit Infant/Toddler Mental Health graduate certificate.
- Completion of professional development workshops.
- Completion of the Oregon Infant Mental Health Endorsement®.

Two key benefits of the participants moving through the PSU ITMH graduate certificate program together are that it would:

- Provide a level of common knowledge and terms for the participants to use in their work in Douglas County.
- Build their relationships as they worked through the courses together.

Infant/Toddler Professional Development Certificate

In the first year of the project, participants completed Portland State University's 20-credit Infant/Toddler Mental Health graduate certificate coursework. Appendix A lists the order of classes and Appendix B lists the description of classes offered in the certificate.

The graduate certificate in Infant/Toddler Mental Health: A Relationship-Based Approach is designed for professionals who are working with families who have children from the *prenatal period to 36 months of age*.

Topics	Professional Standards & Program Outcomes
<ul style="list-style-type: none">• Dynamics of infant and toddler development.• Protective factors in family environments.• Risk factors for mental health problems in family environments.• Social, emotional, and developmental difficulties of infants, toddlers, and their families.• Early screening and assessment.• Theories of treatment.• Home- and community-based intervention.• Diagnostic classification systems for mental health disorders in young children.• Collaborative service approaches.	<ul style="list-style-type: none">• Demonstrate cultural understanding and competence in gathering culturally sensitive data.• Implement research-based practices.• Document and communicate effectively information gathered, tools used and results, and progress made.• Use a variety of practices, appropriate to one's training and background, in the context of interdisciplinary promotion, prevention, and treatment.• Use strengths-based perspectives and practices.• Demonstrate multilingual/cultural awareness in the application of interventions.• Evaluate critically the use of interventions for the general population, at-risk populations, and families who have been identified as needing treatment.

Reflective Supervision

Reflective Supervision Activities

- Support the cohort in addressing problems of practice.
- Support cohort in meeting required hours (25 or 50 hours) for Infant Mental Health Endorsement®.

The inclusion of reflective supervision in this project was multifaceted. As is described in its definition, reflective supervision is a major component of the self-care and professional growth for the professionals within the cohort. Additionally, reflective supervision serves to address a variety of issues that are prevalent within a rural community.

One of the issues often experienced in rural communities is the narrative developed about each agency by the participating organizations. There can be the need to break down past organizational and individual histories of the participants in order to both rebuild and develop trust. Through a slow and thoughtful process of developing ground rules and establishing safety, participants can begin to learn from each other as individuals with shared systemic barriers and personal passion for working with families. Another issue experienced in both rural and urban areas is the creation of information silos. Reflective supervision within the cohort helps members develop individual contacts through discussion of social connections and knowledge of existing programs. This further breaks down existing information barriers and group presumptions.

After personal connection is developed among the participants, cohort members can begin to apply concepts of the academic content matter and real-time interventions to their daily professional roles. The participants can support each other with ideas and feedback regarding what they learned from coursework, implementation of techniques with families, and ultimately group feedback and idea generation to continue skill development in the field for each member. Reflective supervision engages professionals in their self-assessment of strengths and areas where growth could be encouraged. Awareness of one's limitations allows the cohort professionals to redirect their interventions and performance while learning from each other as peer mentors and leaders who have shared expertise within each multi-disciplinary field.

The use of reflective practices can transform how the cohort members consider and address the needs of pregnant women and families with young children. A group setting that is reflective in nature can enhance professionals' knowledge, particularly in regard to identifying risks for families that might include physical concerns. It can also foster an exploration of the sometimes harder to name emotional and relational detriments a family can experience. This work can create feelings of reactivity, an urgency or crisis response within the professional that can cause enmeshment, enabling, negative feelings of worth or unrealistic expectations of a family. It can create goals driven by the provider and not the client, which ultimately damage both the worker's and the family's trust with service organizations. Reflective supervision assists the professional to slow down, process reactions, and meet the family where they are; to hear more deeply the personal challenges and barriers without trying to force unsustainable solutions on families.

Participants in the reflective supervision group can develop these skills by sitting in the discomfort of the conversations themselves, rather than simply jumping to solution-based problem solving. Cohort members notice how reactions to the content affect the process. There is personal growth in the holding of uncomfortable or strong emotions in a safe place rather than avoidance of what is really happening for the worker and the family. The group members can coach each other to

recognize these risks and discuss appropriate responses while supporting the different perspectives. These conversations help professionals slow down and consider how their personal biases and cultural experiences may be influencing their work and views of the families they serve. While these conversations can be difficult and require skilled facilitation, the end results lead the participants to experience feeling heard, validated, and affirmed both within the group setting and in their work.

This validation experienced among the group can be a strong support to addressing the emotional stress and toll of this work in addition to professionals' personal life circumstances. During the three-year span of this project, Douglas County experienced the Covid-19 pandemic simultaneous with serious wildfires that left many families and professionals displaced from or experiencing the complete loss of their homes. These life stressors and traumatizing events affirm the importance of the exploration of the parallel process from the child, to the parent, to the professional; allowing time for personal reflection and recognition that what is happening for families is often what is happening for the professional and vice versa.

Reflective supervision offers a form of self-care promotion that is necessary to minimize the frequent transitions and turnover prominent in the social services field, and to hold both professionals and families during this difficult but rewarding work.

The guide both tells the story of Douglas County and offers examples of activities for organizations working towards a coordinated rural IMH structure.

Inspiration for the work - one program officer's story

Coming back to Douglas County in 2016, the community I grew up in, was new and exciting. I brought with me my experiences and knowledge gathered along my professional career path about the importance of early relational health. As a professional working with parents/caregivers and their young children, I found the field of infant and early childhood mental health competencies critical for supporting the parent/child relationship, the foundation of all relationships the child would experience in their lifetime. I had experienced living in a more urban community with adequate resources available to children and families and a supported workforce who worked together to wrap services around families when they needed it most.

As program officer for the Children, Youth and Families department at The Ford Family Foundation, I value listening to the community and learning from the community as a path towards community investment. I was interested in the resources available to parents of children birth to 3 years. As I began talking to people in the community and hearing about resources and needs, we formalized a process of interviewing partners and scheduled meetings to listen more formally and organize feedback.

What we learned was there were services, but not enough of them; there was a workforce supporting families, but they were seeking more education and specific information; and that there were relationships across family serving agencies, but it was limited. A thoughtful multifaceted strategy was needed.

A design team made up of myself, Alison Hinson (executive director of ORIMHA and Douglas County resident), and Ingrid Anderson (Portland State University) met a few times to put the pieces together for this professional learning cohort. My hopes and dreams were to bring a group of professionals together from across a variety of agencies and provide education, reflective supervision, and networking opportunities. My desire was to grow community champions for the important field of infant and early childhood mental health. – Robin Hill-Dunbar

Our Journey with the Douglas County Infant Toddler Mental Health Cohort

There was a need for coordinated services in the ITMH Douglas County community. We saw a high interest in this idea, but there were low resources for support.

We wanted something that was:

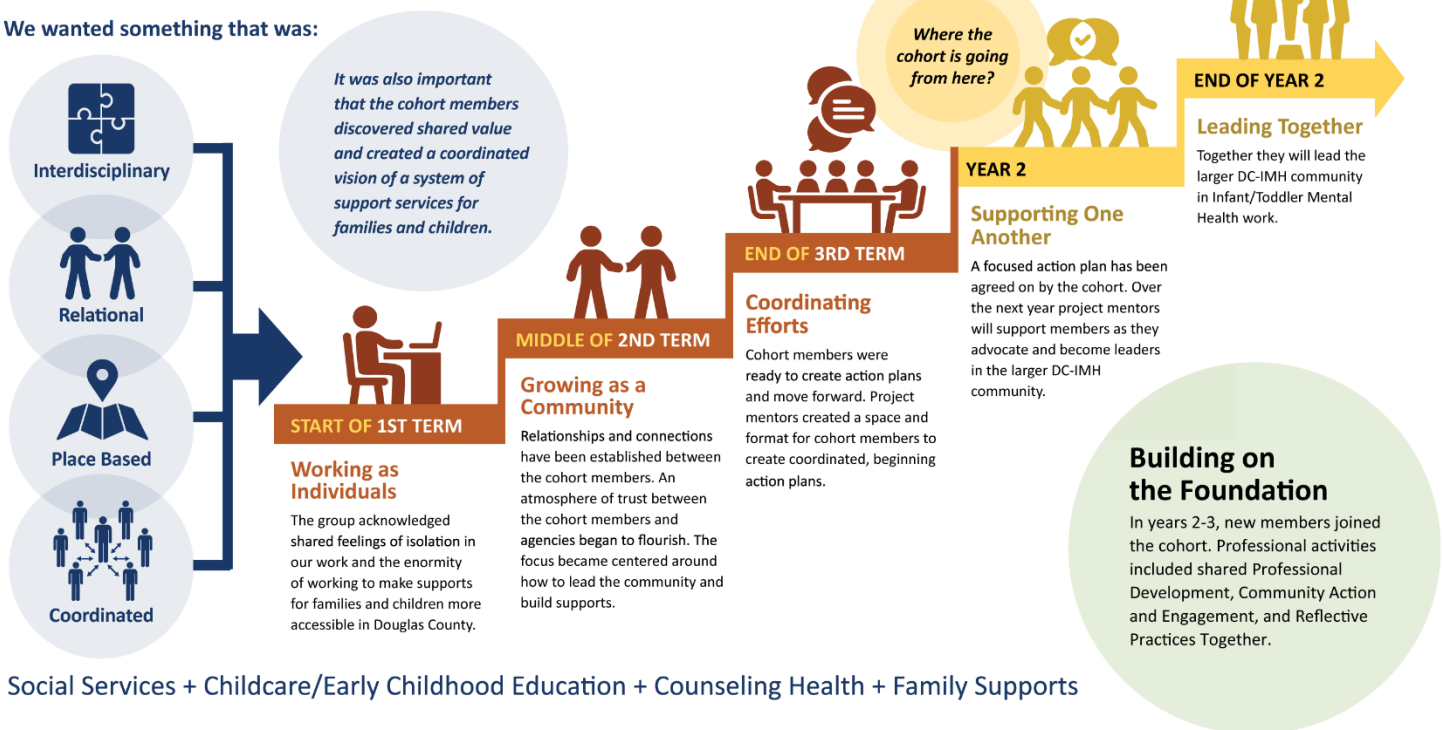
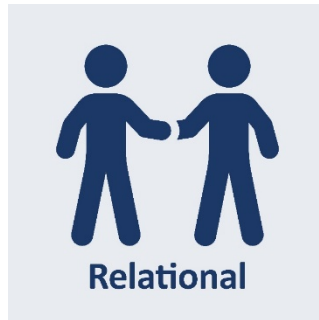


Figure 5: DC-IMH Infographic



Phase 1: Relational

Introduction

Relational work is important on many fronts. We understand that early relationships between caregivers and young children are critical. Relational work is also critical between agencies to create and sustain practices and develop coordinated policies. Relationship-based approaches to coordination of infant mental health is a key for stakeholders as well. Coordination of infant mental health goes beyond those directly involved; it needs to include the decisionmakers in each agency and community leadership. Building relationships helps advocates provide information on the importance of infant mental health. All those in the interdisciplinary field of infant mental health have a sphere of influence and those spheres need to be activated as part of larger coordinated efforts to develop a system of infant mental health for young children and their families.

Setting the Stage in Douglas County

Families often need support from multiple agencies to heal and thrive. However, increasing the number of agencies and individuals that a family interacts with can increase their apprehension, and reset the cycle of trust for the family. Because of this, the mentor team found that building relationships between the participants and their agencies was an essential part of the work. Participants wanted to be able to have connections so that they were able to refer clients to specific individuals for support services, rather than just providing them with a phone number or website.

To build a network of relationships in which the participants felt confident in reaching out to each other, and referring families to additional services, the first phase of the project focused on building relationships. Further, those supporting children and families in crisis need to be able to build a relationship with the family. Many times, families only reach out as a last resort, and fear of losing their children, services, or additional aid makes it difficult for them to trust new people. Oftentimes, families arrive with negative past experiences that also make it difficult to trust those who are trying to help them. Agents who work with families understand the importance of building trusting relationships with their clients and do not want to see that trust damaged.

Additionally, the mentor team wanted this work to continue to grow long after the participants completed their ITMH graduate certificate. Turnover in this field can be especially high in rural areas where support services may have limited capacity for service, such as reflective supervision, for individuals working in children and families. As part of the education focus, each of the participants in our project had the opportunity to complete the Infant Mental Health Endorsement® process.

Networking Meetings

The purpose of the networking meetings was to provide a space in which the participants could come together, build community, and create a shared vision. The meetings provided the mentor team and participants an opportunity to identify common issues and brainstorm collaborative solutions. The first networking meeting was held just after the beginning of the first term. Participants were adjusting to the demands of taking online classes and meeting assignment and participation dates in their already very busy lives. The mentor team had four major goals in this first meeting.

1. Make the participants feel welcomed, valued, and supported in this work.
2. Ease the transition of beginning courses and answering questions about PSU's Infant/Toddler Mental Health graduate certificate.
3. Support the participants in getting to know each other and building relationships.
4. Invite the participants to consider how their work was situated within the wider scope of the work being done within their community.

The emphasis of this conversation was that this was an opportunity to think together and as a substantial piece of the participants' process of coming together as a community. The mentor team members wanted the participants to know that they were there to support them and had a desire to understand and know their needs, both as individuals and as a group. The mentor team encouraged the participants to reach out if feeling frustrated or overwhelmed to help them find a way forward.

***My Dream is
"Networking and making connections with providers and agencies
in Douglas County – to better understand their services and be
able to make direct referrals to real people."
from the Hopes and Dreams exercise***

First Networking Meeting

To ease the transition of beginning courses and answering questions about the PSU Infant/Toddler Mental Health graduate certificate, the mentor team had created personalized packets for each of the participants which included the PSU ITMH handbook, the agenda for the day, and any forms which the member was missing.

First Networking Meeting Template

Welcome

Overview of roles of mentor team

- Mindfulness activity (linking to IMH best practices)

Ice breaker

- Your name, your role
- One word or phrase (or metaphor) to describe your role with infants/toddler/caregivers
- One asset or strength you see in the families/community you serve

Community norms

Overview of grant activities

- What to expect from networking meeting
- What to expect in the ITMH graduate certificate
 - Faculty
- Navigating graduate school

Reflective supervision and how it works

- Endorsement® and the Endorsement® Process

Overview the eco-mapping process

- Hand out Instructions and review
- Creating individual eco/asset maps
- Guided tour of eco-maps/ triads

Food & gallery walk of eco-maps

Dialogue process on eco-maps

- How do we unpack the process?
- What themes do we see in your maps and process?
- What are the assets, challenges, and gaps?

Distribution of resources and materials

Closing – building strengths together

- Balloons (what do you hope for as we move forward)
- Stars (what are you excited about)

First Networking Meeting Resources

- Appendix C: Instructions on Eco-Map & Dialogue
- Appendix D: Hopes and Dreams Activity

Community Norms Activity

The mentor team wanted to create a space in which the participants would feel comfortable having their emotions present as part of the strength of their job. To create a safe space, the participants needed to establish the community norms that would help them to feel safe in our two-year journey together. After discussing, the participants established their community norms. The norms fell into three distinct ideas: relationships, confidentiality, and commitment. After reviewing the norms together, each of the participants and mentor team members signed the document as a commitment to this work.

How to Create Community Norms Instructions

Question: What will it take for you to feel safe in this community as we go on a two-year journey together?

- Partner with someone
- Discuss the question
- Identify one to two core ideas
- Bring forward for discussion

After discussion on community norms and group agreement:

- Everyone signs community norms as part of commitment
- Norms are revisited at start of each meeting

Douglas County Community Norms

Relationships

- *Have patience + grace.*
- *Remember every day is a new day – start fresh.*
- *Have a general awareness that others may be having an off day.*
- *Listen and be present.*
- *Understand who I am – learn a little bit about my life.*
- *Get to know me inside and outside of my professional role.*
- *Assume everyone is doing the best they can.*

Confidentiality

- *Honor confidentiality – for each other, children, and families.*

Communication

- *Have clear expectations.*
- *Clarification – don't assume, ask intentions.*
- *Give constructive feedback.*
- *No judgments – have compassion and understanding.*
- *Be authentic.*
- *Collaborate.*
- *Respect others' time + space.*

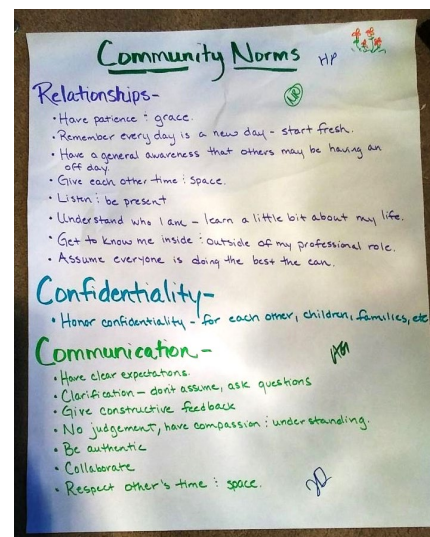


Figure 6: DC-IMH Community Norms

Eco-Map Activity

The eco-maps were a visual map of the participants' community and could be used as a resource to identify strengths and assets, locate resources and power, and figure out barriers and challenges. The mentor team encouraged the participants to see this map as a resource in that community through their work and to visualize themselves and their networks as nested in the middle of many relationships.

Some of the benefits of eco-mapping:

- Eco-maps can assist with mapping strengths, skills, values, beliefs, and can be constructed by multiple parties.
- The process enables participants to identify “gaps” (and related blocks) in resources, knowledge, awareness, power, skills, and relationships.
- Eco-maps allow data to be visually represented, allowing one to see the interconnected relationships.
- They help to center successes of the DC-IMH cohort working alongside infants, toddlers, and caregivers.
- Eco-maps allow the members to capture stories and revisit individually or together and find common and divergent experiences, assets, etc.
- Through changes in eco-maps, mentors can see how connections developed over time.
- The eco-maps serve as a point-in-time measurement of collaborative efforts across services and where gaps in supports or services continued to exist.

Eco-mapping was used as a process to build awareness of the strengths, challenges/blocks, and gaps in the work in the community with infants/toddlers/caregivers. The goal was to revisit the eco-maps over the next year and a half to reflect on how participants' experiences were shaped and changed as they built and expanded the existing networks that supported young children and their families in the community. Detailed Instructions are found in Appendix C.

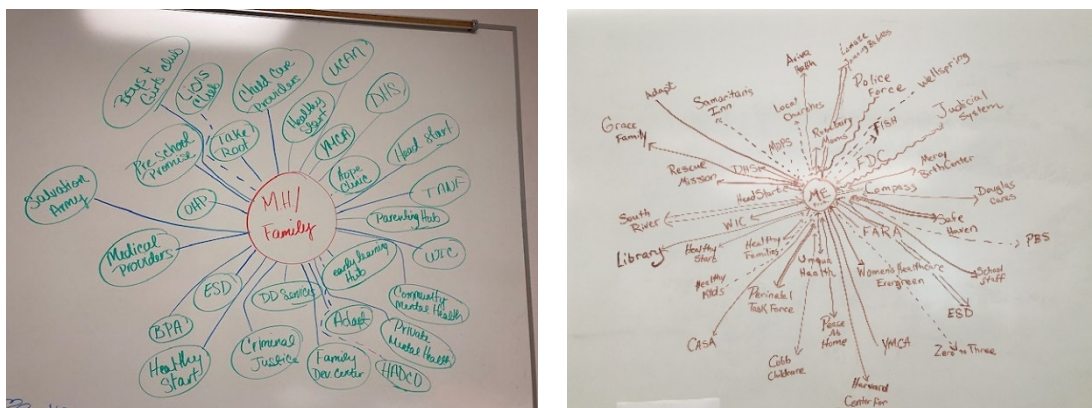


Figure 7: DC-IMH Sample of Eco-Maps, January 2019

As the participants completed their eco-maps, dinner arrived and each member was encouraged to do a gallery walk and explore each other's map. After reviewing and discussing the eco-maps, everyone discussed the process and what larger themes emerged. The conversation began by asking the participants a few leading questions:

- What is already in the community?
- Where do we need to build?
- Where are the holes for community support?

Asking these questions gave the mentor team insight into where the work with the participants would go over the next few years. The themes that emerged were:

- Lack of housing in the area.
- Some supports were not available for families unless they went through the court system.
- Lack of personal connections to other people or agencies in the community.
- The barriers to access:
 - Trust – Families are afraid to ask for help because they may lose their children or funding. The support person’s relationship to the individual or agency is essential for the family to trust.
 - How do we build permanent systems when there is so much turnover in the industry? How do we build systems around positions and people?
- The difficulty in understanding the connections between the agencies and people.
- The need for self-care.
- Concern around families that currently don’t qualify for services or do not have an easily identifiable risk factor but still need help.
- The lack of mental health services for infants and toddlers - children were often “screened out” because the area of concern was not extreme enough or the focus of the screening was on language or physical development.
- Disconnected resources such as churches.

Professional Development as Part of Relational Work

Reflections on Coursework

During the process of creating community norms, areas of discomfort were identified for some of the participants as they were starting their school work. The courses are all designed to encourage interaction, collaboration, and reflection, and it can take a few weeks for groups to find a rhythm to their dance as co-learners that works well for everyone. To help ease the participants into a workable routine, the PSU lead mentor outlined the expectations of work each week.

By establishing an understood routine of the week, the mentor team set the precedence for the work to come. This eased tensions some of the participants were having about other members participating in a timely manner.

The participants also had varying comfort levels taking online courses. The PSU lead mentor walked through the different supports available at PSU. Each member of the mentor team had the experience of working full time while taking graduate courses and understood the level of commitment needed to accomplish this goal. They shared their own stories and strategies with the participants and the PSU lead mentor encouraged the cohort members to reach out if they were feeling overwhelmed or needed extra support, either to the mentor team or to their instructors who also had worked full time while taking graduate-level courses.

Reflective Supervision Builds Relationships

As part of the program, the participants attended two small-group reflective supervision sessions each month. Reflective supervision is a place to examine case studies and for the participants to apply the educational materials they have learned together through reflection. It is a process in which partnerships are created so that participants do not feel isolated in their work or overwhelmed with uncertainty, and so they have a safe place to express the many emotions and considerations that come with their work.^{xxiv}

The reflective supervision mentor spoke briefly about establishing the reflective supervision groups, possible days and times they could meet, and the importance of committing to show up and be present at each session. As a first step to establishing the groups, participants committed to a session in which they would be available to meet with the reflective supervisor and other participants twice a month.

Between our first two networking meetings, participants began to find a rhythm to working full time and going to school. The participatory nature of the courses, along with the reflective supervision sessions, helped the participants' relationships with each other grow and deepen. After our initial network meeting, we decided to create three reflective supervision groups, rather than two, to better fit with the cohort schedules, each of which would meet twice a month.

Looking Forward

From the beginning, the mentor team understood that this process would be emotional work for the participants. To finish our transformative time together, each person in the group was asked to share one hope and one dream that they had for the community. Each of the hopes was shared on a paper balloon, and the dreams shared on a cloud.

“My hope is that we build a network that captures every child and family in need to prevent risk and greatly enhance the quality of life for our community.”

“My dream is new personal and professional insights that enhance the quality of work/services/relationships with partners and families.”

After the participants left, the mentor team remained to debrief and consider the next steps. Much was unpacked that night. They saw where they could continue to follow the vision, and where slight adjustments could be made. Overall, they each noticed how the network meeting had exposed common areas of concern for their community, frustration in the work, and shared goals for the future. Whereas the night began with 12 individuals feeling alone in their quest to support children and families in their community, it ended with a cohesive group that, although still slightly apprehensive, no longer felt alone. They had found partners in which to embark on the journey together.



Phase 2: Interdisciplinary

Introduction

Relationships matter. An interdisciplinary approach involves a small team of individuals across agencies with complementary skills committed to supporting the infant mental health needs of a family, and working towards a shared desired outcome determined by the family and support system together. Grounded in a strengths-based approach, the work focuses on the relationship between the child and the family rather than a specific disciplinary approach. Coordination requires strong interpersonal communication, understanding of relationship building, and the ability of individuals and agencies to compromise and negotiate as they support the child in the context of the family.

Families are included at every step of the way and participate in coordinated processes such as warm handoffs. These are coordinated efforts between individuals working within their agency to assure that families are connected to individuals rather than agencies when services are transferred or added. Further, warm handoffs are best supported by a real-time personal introduction of the family between service providers. Warm handoffs address issues of:

- Continuity of services.
- Clarity of supports (eliminating duplication of services or intakes).
- Increase communication.
- Build relationships between families and the individual service provider.

Setting the Stage in Douglas County

The interdisciplinary process of the project added the next layer to participant relationships. Beyond just being able to tap into each other's knowledge and expertise, the interdisciplinary aspect of the project involved raising awareness for infant mental health in the community through a deeper understanding of how each other's agencies worked, shared language and professional definitions of terms, and being able to identify areas in which more support for children and families were needed.

I see Infant Mental Health as getting a lot of attention. A lot of that is thanks to The Ford Family Foundation for taking on some of these projects as well as PSU providing some of the education. As it is permeating in the different counties and states it is becoming a lot more of a topic of conversation.... We are starting to realize that birth to five really is the time to produce and promote mental health.

DC-IMH cohort member

Beginning the Work - Understanding Place in the Community

Each of the participants had established themselves as valuable pieces in the collage of the child and family support systems within their community. However, individual pieces must connect with each other to create a larger design. To begin this process, the participants needed to first understand where they were seeing themselves within the larger image. It was equally important for the participants to understand where the other members saw themselves. To begin this process, we had the participants participate in the journey mapping activity.

Networking Meetings

Second Networking Meeting

The second networking meeting was held near the end of the second term of courses. As the relationships between the participants grew through taking courses together and attending the reflective supervision sessions, the networking meetings also began to evolve. Although there was still a strong need to address the aspects of working through the courses to earn their Infant/Toddler Mental Health graduate certificate, a desire to become active was common among the participants. The second networking meeting was planned to address:

1. Personal relationships through the journey mapping activity.
2. Professional relationships through the revisiting of eco-maps.
3. Strategic relationships through the “What’s My Headline” activity.
4. Five-year strategic planning activities.
5. Community norms were revisited to anchor the work for the networking session.

Second Networking Meeting Template

Welcome

Ice breaker

Overview of the evening

Community norms

- How would we assure that our group feels safe and engaged at this table tonight and in our learning cohort?
- What might help us continue to build to unity in our efforts together?

Reflective supervision check-In

- Sign-up sessions for individual supports

Reflections

- Mindful minute

Journey map

Discussion - reflecting on eco-mapping

- How are you applying content of the certificate program in your practice? How has your eco-map changed?
- What do you still need/want to explore?
- Dinner – networking conversation
- Discussion
- How do we see our experiences impacting the collective action of the community?
- What new opportunities do we see emerge for Douglas County?

Activity: What's My Headline?

- Report out from small groups on big ideas for IMH

Our collective roadmap

- What would need to happen for us to move forward as a community?
- What conditions made it possible? (timely, accessible services)
- How are those conditions made? (intentional community planning with all resources or potential resources)
- What did it take to design the conditions needed? (building relationships and communication across service organizations, MOUs, data used to identify needs....)

Reflections - Writing

- Using your journey map, headlines, and conversation – take a few minutes to reflect on what you want to put into places in the next few months, next year and beyond. What do you need to make this happen?
- We will be making a copy (or scanning) and return to you (copy tonight /scanning by Monday).

Wrap-up and resource sharing

Second Networking Meeting Resources

- Appendix E: Journey Mapping Activities
- Appendix F: What's My Headline?

Journey Map Activity

A journey map is a visual representation of an individual's process to where they are currently and what they would like to accomplish in the future in their professional and/or personal lives. It begins by the individual creating a timeline that includes significant milestones of their journey and what they are hoping to achieve as they continue their journey. This process includes the actions, mindsets, and emotions that accompany each step of the journey.

Creating journey maps gave the participants the opportunity to gain insight into their experiences to see how they could utilize their experiences to reach future goals.

"We focus on how to get infants to a safe place but we don't focus on how to get them with families and the services they need. We work with five and six-year-olds that have witnessed or been a victim all their lives. We start with 'How do we fix this child' not 'How do we HELP this child' or 'How do we follow the trail to make sure we stop this situation?'"

"There is no work being done around the trauma of the children's experiences. It is all focused on the parents but what happens to the child that goes through 10 foster homes?"

"How do we make it so that medical professionals know what to do, who to turn to, what resources are available, or how to contact them? It could be as simple as a single form."

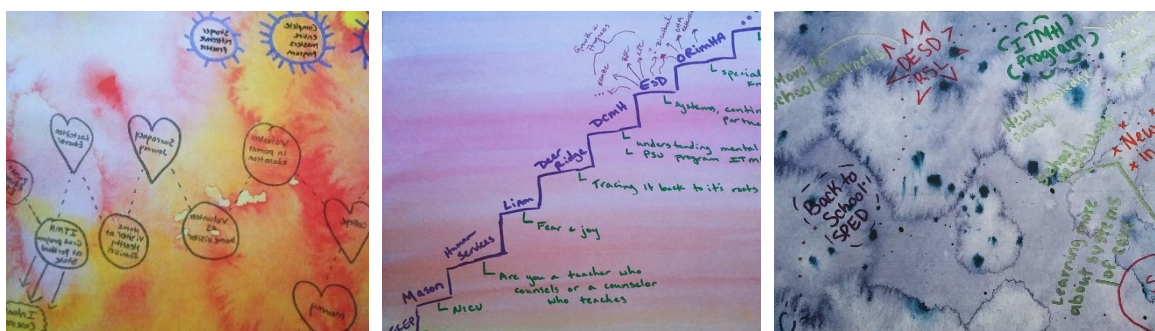


Figure 8: DC-IMH Sample Journey Maps

Once the maps were completed, the mentor team asked the participants to consider how they were applying the content of the ITMH graduate certificate program in their practice. To begin, they asked the participants to notice what seemed to be changing or what was coming to their attention that had not before. Additionally, the mentor team asked the participants to think about where they might see their work in IMH going forward in the future. After some time for reflection, the participants returned to a full group conversation guided by the following leading questions:

- What are the barriers and/or gaps to Oregon state policy to IMH?
- What agencies should we bring in to fill in those gaps?
- As resources grow, how do we become proactive rather than reactive – to be resource-rich rather than scarce?
- What are you seeing that will be helpful to move the work forward?
- Think of one group that would be pivotal to help you make a change.
- Who is missing from this room who could scaffold and build on your work?
- Where are the untraditional places/people that interact with mothers and families?

The conversation centered around the overall lack of knowledge of infant and toddler mental health in the community, even among those whose work was centered around supporting young children and their families. This included the court system, the medical field, and first responders or caseworkers that interacted with families and young children at the moment of crises. The participants considered ways in which they could immediately address the issues, such as providing checklists for first responders and case managers, and resource lists that medical professionals could provide to families in need. They also spoke about ways in which they could deepen the community's knowledge and connections, including broadening IMH knowledge and understanding and teaching parenting skills. Additional thoughts were about how they could shift the focus of support from just getting children and families safe, to long-term support and care that empowered families and stopped the cycle of abuse, violence, and poverty.

At this point, the mentor team began to see a shift in the attitudes of the participants as the participants began to see themselves as a group of experts figuring out how they could lead their community and increase awareness around IMH. The next step in the work that night helped to further this journey. The participants broke into groups of three or four and the mentor team introduced the next activity.

What's My Headline Activity

In this activity, small groups work to develop a headline of events that they wish to achieve collaboratively over time. For the DC-IMH cohort, we asked participants to create a headline for five years in the future. The activity served to also lay the steps for the first items on a five-year strategic plan.

Headline actives include:

1. The main headline.
2. A secondary headline.
3. Two to three "quotes" from "people" commenting on the success of the project.
4. Two to three boxes that represent "photos."
5. A key paragraph describing events placed under the main headline outlining activities.

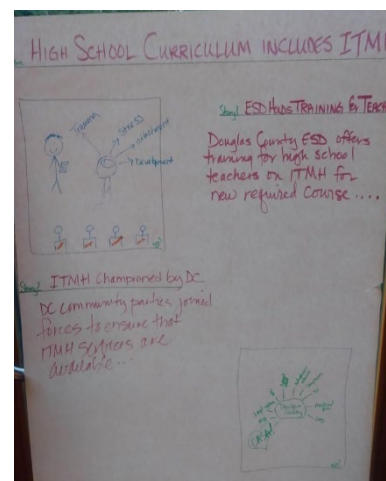


Figure 9: DC-IMH What's My Headline

The participants loved this activity and embraced it with enthusiasm. When it was time to come together again to discuss their ideas, it was a challenge to get them to leave their work. In reviewing and discussing the “e-news headlines” that the participants had created, the mentor team could see how they were already thinking about how the gaps and improvement areas discussed earlier could be addressed. By envisioning the future, the participants were laying the groundwork for their future work in their community.

Professional Development as Part of Interdisciplinary Practice

Between the first and second quarter of the ITMH graduate program, most of the participants thrived in balancing the responsibilities of work, school, and home, while a few still struggled. Actively participating in online courses offers the flexibility for an individual to work around their own schedule, yet participants are expected to dedicate a minimum of 20 hours a week towards their courses when taking five credits per term. Two of the participants opted to postpone the completion of the ITMH graduate program at this time.

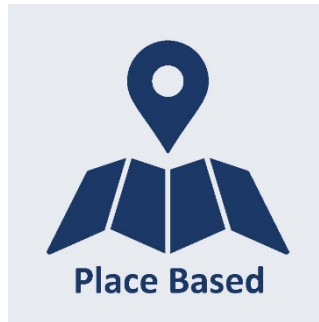
Reflective Supervision

At this initial phase of the reflective supervision sessions, participants balanced the tensions of building trust and getting to know each other. The group explored how best to talk about their own agency work while dancing with the idea of confidentiality and how much was appropriate or safe to share without fear of “getting in trouble” with their own agencies. The reflective supervision provider specifically placed members of each organization in separate groups so that they could feel more confident that their peers would not take information shared back to their organizations, and so that participants could build new relationships with others who had perspectives for a different organizational lens.

The structure of the groups imparted a more collegial feeling as individuals shared at a safer surface level. As goodness of fit was evaluated with each group, adjustments were made to the reflective supervision groups to better align with schedules and personalities. To build depth of sharing in a safe manner within the group, the reflective supervision provider took a more active role and brought relatable discussion concept prompts for the group to process such as the idea of shame, client motivation barriers, etc. This allowed participants to connect sharing to their personal work experiences with less direct interaction than sharing something more personally intimate.

Looking Forward

The participants’ enthusiasm for the work they would be doing in the community continued to grow. However, at this point they had not yet settled on a shared vision of where to start. A few of the members felt that any action was positive action, whereas other members wanted to make sure that they represented IMH and their agencies with a consistency that would increase understanding and not cause confusion in the larger community. It was time to start creating a shared vision of where the participants wanted this work to go in the community.



Phase 3: Place-Based

Introduction

Place-based policies and support services in many states can be focused on where the majority of the population is situated and can be disconnected from the needs of rural communities. For instance, what good are housing subsidies when there is a lack of housing available? How do early childcare and early childhood education subsidy vouchers help when there are no spaces available in qualifying programs? Furthermore, the support needed in one rural community in comparison to another can vary significantly. Involving participants from the same community but with different expertise in the field created a unique opportunity in which the needs of the larger community were able to be considered from a variety of perspectives and understanding. This created the opportunity to define a shared vision for the future of IMH work in their community.

Networking Meeting

Third Networking Meeting

The third network meeting began by re-centering the participants to their positionality within the community and revisiting the journey maps they had created in the last session. This time, the mentor team asked participants to add layers to their journey maps that demonstrated how they were applying the content they were learning from the ITMH graduate certificate program to their practice, what was changing, and where they imagined themselves going in the future with their work in infant mental health.

Third Networking Meeting Template

Welcome & check-in

Ice breaker – 3D tree – write one small victory you have had since we last our last meeting. Find whomever has your matching leaf and share your victory. Then go hang your leaf on the tree. For our next meeting we will have a 3D tree to continue adding leaves to.

Review community norms. List a word that resonates with you today?

Reflective supervision updates

Reflective activity – arts-based revising our journey maps

- *Participants revised their journey maps*

Reflection questions

- How are you applying content of the certificate program in your practice?

Reflections on journey maps:

- What seems to be changing or what have you noticed?
- Where do you see yourself going with your work in IMH?

Creating a shared vision – choosing collaborative activities

Request for content in upcoming meetings

Screening of **No Small Matter**

- Small group discussion at end of film
 - How do we bring IMH into the conversation?
- Reconvene group
- Report out from small groups

Continue to chart activities onto five-year calendar

Wrap-up and resource sharing

Third Networking Meeting Resources

- Appendix G: *No Small Matter* Screening

Revisiting Journey Maps

A natural progression to revisiting the journey maps was seeing where there were still gaps in the expertise of the group, and how to expand the network. At that time, there were several graduates of the PSU ITMH graduate certificate program who were living and working in Douglas County, and an easy way to expand the network would be to invite them to some of the meetings. The mentor team saw this as an essential part of the process, yet at the same time did not want to disturb the circle of trust that had grown over the year.

The conversation by revisiting the original vision for the cohort program: that we had planned for the networking meetings to be for about two years and then intentionally create a larger group where everyone had expertise in infant mental health. This would include both individuals in the community who had completed the Infant/Toddler Mental Health graduate certificate, those who were starting that program the next year. The larger group would continue the work started by the participants and cohort. The feelings of the participants around this idea were similar to those of the mentor team – they saw a need to grow, yet they were concerned about how it might affect the synergy they had developed over the past year.

Overall, the participants were excited to expand their network. Many of them had particular people in mind that they wanted to refer to the program. The mentor team shared the many different scholarship opportunities available for the upcoming year and how to refer someone to the program.

No Small Matter Screening Activity

An additional goal of the group was to take leadership roles in the local IMH community. The participants had several different ideas of how to do this. Some of the ideas presented by the participants in the past included increasing public awareness. A movement happening at that time in Oregon was the documentary *No Small Matter*. The mentor team ordered access to the documentary to share with the participants as a consideration of a possible public awareness event.^{xxv}

While introducing the film, it was noted that in conversations around early childhood care and education, early mental health was often left off the table. We invited the participants to think about how they could bring their voices and the work that they do to the conversation as they watched the film.

- What parts of the film were strong and what was missing?
- Where could we join the efforts of other Douglas County entities promoting this film to early childhood care and education providers and families?
- Who else can we partner with to amplify the message of the film to additional stakeholders?
- In what ways could we use this film to connect with the participants' five-year vision?
- How do we support the work already being done around this film in Douglas County without reinventing the wheel or duplicating efforts?
- How do we see our experiences impacting the collective effort around this topic?
- How might we build on our collective action?
- How do we bring people in?
- What topics do we want to introduce?
- How do we bring a strengths-based perspective that deepens the conversation instead of replicating what we already know?

After watching the film, the participants met in small discussion groups before heading into a whole group discussion. After meeting for 15 minutes, the group came back together. Although much of the conversation was about what more the participants could do, and what else needed to be done in Douglas County, it ended with a focus on how Douglas County has been increasing support for children and families over the last few years. These items were added to the Five-Year Collective Roadmap. The participants completed the evening excited and energized.

Professional Development as Part of Place-Based Work

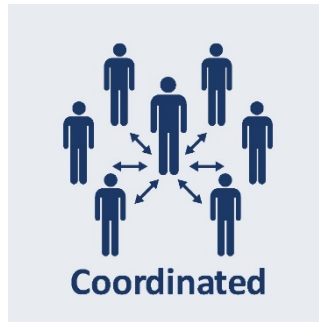
The participants finished their third quarter of classes and began to see that the completion of the ITMH graduate certificate was just around the corner. The mentor team saw this as well and considered how to provide the participants with the resources and tools to empower themselves to continue the work they had been doing. To do this well, the mentor team was aware that in whatever direction the participants took this work, it needed to be decided and led by the participants themselves. Even with the goal being so close, the number of participants in the cohort decreased again by one when one person's family commitments increased.

Reflective Supervision

While most groups go through a phase of conflict as they learn to adjust to being with each other in this type of shared space, the groups demonstrated cohesiveness fairly quickly. This is partially due to the rural community setting where many of the participants had at least some level of professional crossover, in some cases over multiple years. The cohesiveness also was strengthened by the group members' commitment and follow through with respecting the ground rules. This reaffirmed trust and respect after each session, thus making it easier to share more openly and deeply as the groups continued. Participants shared about the connections they had personally to the work they perform, their worries for families they work with, and some of the systemic challenges of the field of infant-toddler mental health.

Looking Forward

The conversation that began with *No Small Matter* in our network meeting continued in the participants' coursework as well as when they would come in contact with each other throughout their work. There were many different areas in which the participants believed that IMH education could benefit their community. The barriers that the participants had discussed were still relevant, yet now the conversation had evolved from just identifying the barriers to considering workable solutions on how to break them down.



Phase 4: Coordinated

Introduction

Coordinated approaches to IMH require sustained work over time. As individuals become comfortable in groups and start to implement strategic planning, messaging becomes particularly important. Strong strategic alliances recognize that time must be spent on the relational work with the members of the collaborative. The building of relationships through networking meetings, professional development, and reflective supervision is the primary focus of the first year of a multi-year project. This can be frustrating for partners used to moving fast, but research on successful collaborative models focuses on the importance of relationships for long-term stability and sustainability of a coordinated infant mental health system. As relationships build trust, the outward-facing work of a coordinated approach begins. Coordinated services and interdisciplinary practices start to move into operational stages of development, setting the stage for advocacy and ultimately policy development. The focus at this time moves to coordinated messaging emerging from the shared understandings developed during the first year of the project.

Setting the Stage in Douglas County

I see strong collaborations at the state level with policy I see a lot more and perhaps it is because I am looking more than I used to but I am seeing a lot more interaction with legislators and Zero to Three through some national programs that we are starting to adopt as a state. At a community level, it is becoming more of an emphasis for program development in taking more interest in infant mental health than ever before.

DC-IMH cohort member

The process of building relationships, increasing the participants' interdisciplinary knowledge, and defining a shared vision for the future allowed the participants to coordinate critical areas on which to focus their energy and resources. The goal was to increase knowledge about infant mental health in the community and connect with the additional support systems that were not currently at the table. The mentor team supported the participants as they did this work throughout the second year of the project in networking meetings four, five, and six.

Networking Meetings

Fourth Networking Meeting

By our fourth networking meeting, the participants had defined five focus areas to increase IMH knowledge in the community. These were: training teachers to teach IMH classes in the local high school; training pediatricians and OB-GYNs on IMH; an overall community education plan to build IMH and maternal health awareness; in-home foster parent training on IMH; and working to create Baby Court supports and processes in the community. However, a fully shared vision had not yet been defined. To work through the process of creating a shared vision, the mentor team began by having the participants create action plans for each of the areas. We asked the participants to identify the two ideas that they felt most passionate about. They were given 30 minutes to work with the other participants who chose the area to start to create an action plan template (Appendix I).

Fourth Networking Meeting Template

Welcome

Mindful activity

Three-minute infomercial

- Your name
- Agency you work for
- Top three ways your agency support children and families
- Top three responsibilities of your job

Global cafe

- Round one (30 minutes): Return to your original action plans
 - Review your action plan
 - what else needs to be considered?
 - List, add, make edits
 - Choose one person to stay as the ambassador
- Round two (30 minutes)
 - Visit a different action plan
 - Listen to the ambassador
 - Ask questions, make suggestions
 - List, add, make edits

Grab dinner and move to a new action plan

- Round three (30 minutes)
 - Visit a third action plan
 - Listen to the ambassador
 - Ask questions, make suggestions
 - List, add, make edits
- Round four (30 minutes)
 - Visit final action plan
 - Listen to the ambassador
 - Ask questions, make suggestions
 - List, add, make edits

Decide which action plan you want to work in

- Brainstorm with other action plan group members
 - What do you need to do to launch this plan in February?
 - Who do you want to invite to join the team?
 - How are you going to invite them and present your idea?
 - What support do you need?
- Regroup and discuss next steps

Continue to Chart Activities onto 5-year calendar

Wrap-up and Resource Sharing

Fourth Networking Meeting Resources

- Appendix H: Global Café
- Activity I: Action Plan

Three-Minute Infomercial Activity

The three-minute infomercials were a quick way for the participants to share information about themselves, the agency where they work, the top three ways their agency supports children and families, and the top three responsibilities of their positions. Each individual's sharing inspired questions from others, as well as helped the participants notice areas of connection that had not been illuminated previously. The questions asked encouraged the participants to share where they saw shortfalls in their role and/or the agency where they worked, and were an unanticipated bridge to the next activity.

Action Plan Activity

The next activity was to have the participants revisit their action plans from the previous networking session. The participants began with their original action plan and team. Together they reviewed the plan and addressed what more needed to be considered. Next, they listed, added and/or made edits and updates to the plan. After 20 minutes, one participant stayed at each action plan to act as an "ambassador" while the rest of the participants visited other action plans. The ambassador shared the team's thoughts and ideas with each group, answered any questions, listened to suggestions, and added or made edits to the action plans.

The participants rotated three times.

The groups then had time to come back together with their original action plan team members to listen to the updates and suggestions that had been made. They considered the following questions to bring back to the whole group:

- What do you need to do to launch this plan in February?
- Who do you want to invite to join the team?
- How are you going to invite them and present your idea?
- What support do you need?

The whole group conversations led to some interesting conclusions. First, the work that needed to be done for each of the action plans overlapped in some areas. Second, the scope of the work that needed to be done for each action plan was too much for the number of people on the team. It was decided that the group should narrow their focus down to one action plan. However, after much debate there was still a strong interest in two different areas. The first choice was establishing a Baby Court in Douglas County. The second was to find ways to educate medical providers about infant mental health. It was decided that the participants would continue their work in these two areas and that a final decision would be determined at the next meeting.

The mentor team continued to search for resources for the participants in the two areas of interest that they were focusing on for their action plans. They transcribed the work completed in a shared document that was able to be edited and updated by all and applied for a grant that would support the participants in bringing Baby Court into Douglas County. Meanwhile, the cohort members completed their final term of courses for the Infant/Toddler Mental Health graduate certificate and began to apply for graduation in the spring.

Fifth Network Meeting

Our fifth network meeting began by providing the participants with the opportunity to contribute any ideas they had for the graduation celebration or letting the mentor team know of any unfinished business that needed to be addressed. This was incorporated as the participants arrived, gathered refreshments, and settled in.

Even though the participants had made some great connections as they had been taking courses and participating in networking and reflective supervision meetings together, there still seemed to be a need for deeper understanding in what each person actually did for work. The next order of business was to address this by providing each participant and member of the mentor team to present a three-minute infomercial.

Fifth Networking Meeting Template

Welcome

Mindfulness activity

Introduction of DC-IMH infographic

- Introduce individual infographics, follow the steps, you will show in a 3-minute presentation during dinner
- Work on individual infographics about self within agency

Dinner arrives, get food and settle back into room

Present infographics during meal – 3 minutes each

Transition activity – revisit balloons

Review ppt – where we have been

Five year strategic plan revisited with action plans

Talk about next steps, look at survey results, do scatterplot

Form next step groups, follow leading questions, create a presentation of what you want to do and what support you need.

Groups present plans, make suggestions for support

Finalize plan for next meeting

Resources

Fifth Networking Meeting Resources

- Appendix J: Info Graphic

Info Graphics Activity

Sixth (and Final) Networking Meeting

The final networking meeting started with a quick check-in with the participants and mentor team. After going around the room, it was clear that everyone was tired. This was somewhat understandable as it was the end of the first full week back to work after the holiday break for most.

Sixth Networking Meeting Template

Welcome & snacks

Overview of guest speakers for the evening events

Oregon Child Development Coalition: Mental Health Consultation Model

- Overview of the project
- Lessons learned in rural areas
- Handouts
- Short discussion – implications for own work

Presentation and discussion: At the intersection of typical social-emotional development and infant mental health

Food & discussion and implications of professional development on our work

Updates

- CERA grant – still waiting to here
- Planning for outreach / next speaker
 - [Dr. Amy Stoeber](#) – ACES and resiliency

Networking Meeting Activities

The mentor team invited guest speakers who had experience sharing information about what infant and toddler mental health is and how to support children and families through a mental health lens to the final cohort meeting. The first speaker was Patricia Cavanaugh from OCDC Mental Health Consultation Model for Early Childhood and Home Visiting to share the work she had been doing with providers in two rural communities in Oregon. The second speaker was Dr. Jean Barbre, who talked about what led her to write the book *Foundations to Responsive Caregiving*.

Although the participants were tired, the presentations encouraged a lively conversation and many of the participants reconnected back to their action plans that had been slightly abandoned over the last two months as they were completing their final courses, continuing their daily work, and gearing up for the holidays. The participants connected with many things both speakers shared, such as the wide range of knowledge about IMH in the mental health field, the variety of terminology used to describe IMH, and the stigma that often surrounds the term “mental health.” They also connected with the lack of resources described by Cavanaugh, as they discussed how increasing shared knowledge and terminology might also increase resources in an area.

The conversation then returned to how the participants could get IMH knowledge into the community. Who was most important to get IMH knowledge first? Where would this knowledge make the most impact in the community? Ideas included parents, pediatrics and OB-GYN providers, policymakers, and early childhood educators and preschool teachers. It was suggested that bringing in additional experts who had done this work successfully would be helpful in the future.

After the meeting had concluded and the participants had left, the mentor team met to debrief and plan for the next steps. It was agreed that at this point there was not a cohesive focus from the participants of how to move forward. Over the past term, attendance for reflective supervision sessions was down due to end of the year responsibilities, illness, holidays, and family visiting. Everyone seemed as if they needed some time and space to breathe. The participants were at different stages of comfort in moving forward. Some of them were ready to lead, some were more than happy to follow, and everyone still felt unsure of what the next step should be as we were still waiting to hear back on our grant application. There was some trepidation around the process for the different levels of Endorsement® and the mentor team wondered how we could balance the support to meet the participants' needs for Endorsement®.

Professional Development

It was decided to use the next month to let the participants get back into the routine of their reflective supervision sessions, and start making their Endorsement® plans. Meanwhile, the mentor team planned a graduation celebration for the participants. The celebration offered the opportunity for the participants to reflect on and celebrate the work they had done over the past year with their families and as a group together. Additionally, the mentor team discovered that they were not awarded the grant they applied for to fund the participants to bring Baby Court to Douglas County.

Graduation Celebration

I am so grateful for the work that PSU has put together and the journey we have been able to go through as a cohort with The Ford Family Foundation helping us because I think none of us would have the career focus we have without it and families are being touched in a way they would not have known to touch before.

DC-IMH cohort member

The graduation ceremony was held at the end of February 2020. Families were invited, dinner was shared, a short presentation was held, and speeches were made. It was a joyful night and a sense of pride and accomplishment filled the room alongside an anticipation and excitement for the work to come. Unbeknownst to us, it would be the last time we were together in-person for over a year.



Figure 10: DC-IMH Graduates

Reflective Supervision

At this phase, participants in the reflective supervision groups had developed enough trust and connection to begin providing supportive questioning and exploration with each other. Participants began to experiment with new ideas and behaviors as an egalitarianism mindset developed. Participants helped each other increase their self-awareness and personal growth by—challenging each other’s biases in a respectful way, from a place of kind curiosity rather than judgement. Participants actively helped and supported each other and in doing so, recognized the parallel process of being both the helper and the receiver. Participants reported the use of the time and reflecting space as extremely helpful in developing more adaptive coping mechanisms, particularly through the experience of the onset of the Covid-19 pandemic and the severe wildfires which occurred in the Fall of 2020. Team productivity and effectiveness occurred as both personal and professional relationships deepened, and broader connections were made within the ITMH system in Douglas County.

Looking Forward

I am very excited about the future that it holds and I think it is really hard to measure prevention, it is hard to measure how many kids didn't fall through the cracks because they didn't fall through the cracks. I really hope this work continues momentum even when some of the benefits we may never be able to measure.

DC-IMH cohort member

The courses were just the first step of the project and provided the participants with shared knowledge and understanding about infant and toddler mental health. While the participants were taking courses, one of the responsibilities of the PSU mentor team was to plan and lead network meetings with the goal that the participants would continue to meet on their own.

Responding To Community Needs Together

Within two weeks of our graduation ceremony, the world had changed very quickly. By mid-March, in response to the COVID-19 pandemic and the increases of cases in Oregon, all K-12 schools statewide as well as colleges and universities were shut down and began the transition to online learning. The Oregon Early Learning Division was scrambling to find ways to support children and families who were unable to stay home. The participants quickly adjusted to how to serve their clients remotely and began to anticipate the increasing needs that would surface with a surge in statewide unemployment and housing insecurity.

Although everyone was dealing with a lot due to the COVID-19 pandemic, the mentor team decided that the best way to not lose momentum was to continue to move forward. The participants continued with their cohort work. This included attending their reflective supervision sessions and meeting with the other participants to continue the work they had started during the networking meetings as well as work they were doing within their agencies. The work the participants were doing within their agencies took precedence as it was focused on meeting the

The cohort meetings gave participants the opportunity to share the work they were doing, connect that work between agencies, and tap into additional resources. A notable amount of work was centered around educating staff and other coworkers around what infant and toddler mental health is and why it is important. This included advocating to use agency funds for professional development around parent-child relationships, attachment, and becoming certified lactation counselors. Additional policy-level work was happening as well, both through individual conversations and panel presentations.

To reevaluate their positions in the community, the cohort created new eco-maps. The new maps were much more organized than the previous attempt. In doing this exercise, participants noticed that their level of knowledge about agencies and who to contact in them was much greater. For agencies that the individual did not have a relationship with, they felt confident that they could make a connection.



Building Capacity Over Time



The conversations in our community and the education around the need for IMH specialists, there is an awareness that there are issues that can be accessed, and I think as people are learning that we don't have to wait until children are age 5 to discover that we can support children, that conversation is growing.

DC-IMH cohort member

Growing Impact

The relational work that began in the collaborative model of networking meetings, professional development and reflective supervision started to expand into a strengthened foundation of relational work in rural communities.

- Advocacy and policy development – Localized advocacy continued to grow and strengthen as the initial cohort's work gained momentum. The cohort became aware of Oregon Medicaid reforms that had been implemented and began to discuss an advocacy campaign to health professionals. Cross-sector professional presentations increased awareness. A public campaign was designed by the cohort and those who joined from a second scholarship round to increase awareness in the community.
- Coordinated services – Service delivery among cohort members increased in coordination as the expanded cohort worked together. New services and a new mental health agency expanded services. Several cohort members were promoted or moved into new positions, bringing their knowledge and influence into new agencies and sectors serving young children and families.
- Interdisciplinary practices – Continued coordinated services and interdisciplinary practices reinforced the identification and dissemination of tools and resources that supported families to understand and respond to the mental health needs of young children

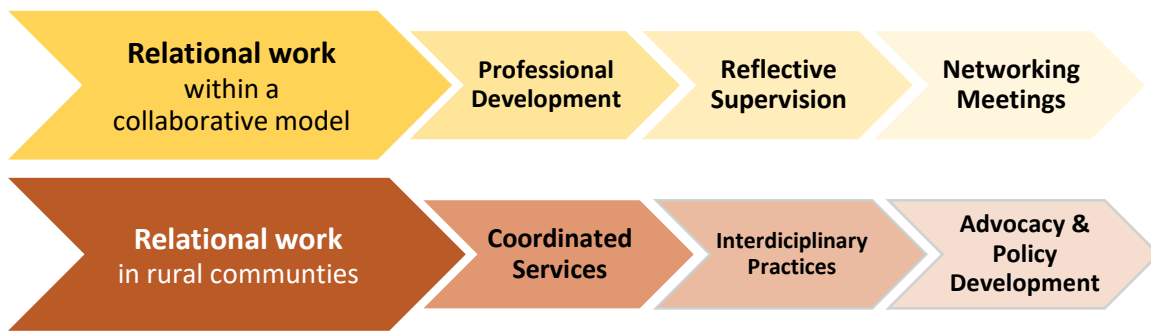


Figure 12: DC-IMH Relational work

Professional Development

One area that continued to frustrate the participants was what appeared to be a lack of recognition from primary care providers, such as pediatricians and OB-GYNs, about the importance of infant, toddler, and maternal mental health. They knew that if they could find a way to increase this recognition and encourage doctors to make referrals, they could reach children and families in need before they hit crisis mode. However, they also knew that if they were able to get in front of the medical profession, they would have one chance to make an impression.

The mentor team organized five two-hour sessions in which the participants could work with Dr. Amy Stoeber, a licensed psychologist who specializes in promoting resilience for families, healthcare entities, schools, businesses, and individuals. Dr. Stoeber’s experience in working within systems, such as schools and the medical world, connected strongly to the work the cohort wanted to do moving forward. Additionally, bringing in Dr. Stoeber presented an organic opportunity to connect to other professionals in Douglas County who had completed or were completing the Infant/Toddler Mental Health graduate certificate program at Portland State University.

The first session with Dr. Stoeber was held in January of 2021. It was the first time the participants and mentor team had met – even virtually – since the graduation celebration almost a year before. Additionally, four new professionals accepted the invitation to join the sessions and possibly join the participants in their cohort work. Two had completed their ITMH graduate certificates in 2018, one in the summer of 2020, and the fourth would be finishing in the summer of 2021. A few of the participants were familiar with the new group through their work, and some had never met before. To help everyone connect and reconnect, the first session began with each person doing a brief introduction about themselves, their work, and their role in the Douglas County Infant Mental Health cohort project.

Throughout 2020, the participants had been negotiating how to support their clients virtually and meeting the increasing needs of the community, and it only made sense to begin our sessions with Dr. Stoeber with a focus on self-care. The conversation around self-care naturally

transitioned into resilience, including the resilience that participants had seen in community members. The concerns around what was to come next, as vaccines became available and children would be able to return to school, was high on the participants' radar as they wondered how the increasing mental health needs of the community would be met with the support systems were already so overwhelmed.

The next three sessions were focused on understanding the systems that were already in place, such as schools and the medical community, then considering how these systems could incorporate a mental health lens. Dr. Stoeber shared her strategies for helping providers build compassion for families and understanding intergenerational trauma. The participants expressed a shared knowledge that pediatricians and OB-GYN doctors rarely had the time to consider their patients' mental health. To get doctors "on board" they would need to make the content of the ITMH graduate certificate synthesized in a way that was easy to understand and cost effective.

This conversation continued in the final session as the participants worked with Dr. Stoeber to consider the best ways in which to present their ideas. Much of the discussion was about the shifting national conversation around mental health as a state of well-being rather than only as an illness or crisis. Even with this shift, the participants believed there was still a strong stigma attached to the term "mental health" that kept many people from seeking treatment before getting into crisis mode for fear of being labeled as a bad parent or even losing their children.

The sessions with Dr. Stoeber helped participants have a deeper understanding of the work they wanted to do in the near future. The additional levels of expertise brought in by the new members of the group also increased this understanding and narrowed their focus. There was still some discussion to have around fine-tuning their plans, and the mentor team and participants agreed to meet virtually once a month to continue this work.

While attending the sessions with Dr. Stoeber, the participants had continued with their reflective supervision sessions and were going through the process of achieving their Endorsement®. The work the participants were doing both through their agencies and as a group was increasingly leading to how they could educate medical providers about the importance of infant, toddler, and maternal health as well as reduce the stigma associated with mental health in the local community.

Networking Meetings

Working lunches

To continue the transition of the participants leading the work, the mentor team organized working lunches once every three weeks. The working lunches were hour-long virtual meetings in which participants met to discuss their work together. Through the working lunches, the participants narrowed their focus of this work to educating the medical profession on infant, toddler, and maternal mental health and destigmatizing mental health in their communities.

The effort was to come from two angles. The first angle would be an audio/visual media effort that would outline the key concepts and core ideas, and visuals about the work they had been doing and the resources available. The second angle was to create visuals that families and doctors could use. One would be focused towards professionals about why IMH and maternal

health was important, and the second would be focused towards families. The handout for families would have one side about IMH and attachment, with the reverse similar to a game board, with different family activities that supported children’s mental health and built attachment.

Working Lunch Template

Action-oriented 60-minute meeting

- Welcome & centering exercise (5 minutes)
- Action focus of the meeting (5 minutes)
- Breakout groups (25 minutes)
- Report out & next steps (15 minutes)
- Individual and group announcements (10 minutes)

The working lunches provided the participants a place to connect, reflect on the work that they did over the past year, and to connect around the two angles in which they were working. These were, of course, on how to educate the medical profession on infant, toddler, and maternal mental health and destigmatize mental health in their community.

Working Lunches Infographic

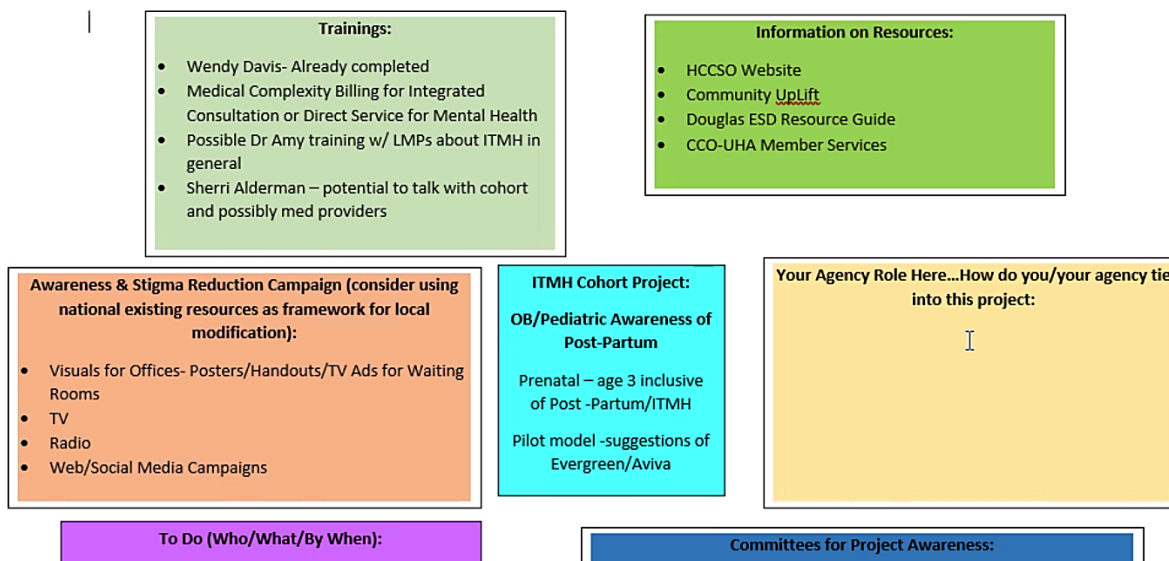


Figure 12: DC-IMH Working Lunches Infographic

Reflective Supervision

The participants had moved into a collective by this final group phase. Participants were able to support each other through a cathartic use of the group space, working with each other through release of emotional tensions and expressing emotions in a safe environment. The level of sharing and emotional tensions moved through phases of supportive and conflictual as can be the case when holding tensions in a group that has developed deeper relationships and personal expectations of each other. These conflictual tensions were managed in whole group and smaller partnership discussions, ultimately leading to participants taking responsibility for their own actions and recognizing the impacts on others, leading to resolution and reconnection.

As the groups began to come to a sense of closure, for the participants, the feeling was that the groups were a whole collective made of individuals whose experiences were different but clearly intertwined. The participants moved into discussion and review of actual outcomes and achievements, exploring feelings of what worked and what didn't over the course of the project. These discussions helped the groups process the remaining challenges and barriers they experienced within the IMH system and any feelings of loss as the groups began to come to a close.

Looking Forward

The participants continued to work in their subgroups towards the goal of promoting mental health to medical professionals in their community. Each group worked independently with the support of the reflective supervision mentor. In addition to this work, the participants wanted to share their experiences with the wider community. The opportunity to share their work was achieved presenting at the Systems of Care breakfast in August of 2021.

The Ford Family Foundation, in partnership with the Douglas County Systems of Care, hosts a monthly gathering. The gathering is for anyone interested in or supporting children and youth's behavioral health needs in the county. The breakfast was started in 2018 as a way to build relationships, increase collaboration, and share available services on behalf of children and youth. In March of 2020, the breakfasts shifted to a virtual platform.

Participants continue to work together as collaborative partners of shared client families, referral sources, and to build new programs to fill gaps. Interested participants were invited to continue with reflective supervision after the formal group processes ended. Master's level clinicians within the cohort were also invited to continue training to become reflective supervisors themselves to build further provider capacity in the community.

Final Group Project Work

Enhancing awareness of infant and toddler mental health across the community, particularly within medically focused environments serving primarily children and women, will continue to be the focus area of this group. As medical partners are often the first individuals to hear family concerns regarding postpartum-related symptoms and early childhood behavioral and relational needs, they are an important contributor to helping with early identification and referral for families. These partnerships can also assist in stigma reduction so families and individuals can normalize a need for support and services for themselves and their children.

Ripple Effects – Voices of experience.



Introduction

As the project entered the final six months, the mentor team wanted to offer the participants the opportunity to reflect and share their experiences and the work they are doing that was influenced by their participation in the DC-IMH project. Throughout the educational and collaborative experience, this group of participants has reflected on several aspects of the journey. They share some of the key pieces of collective wisdom.

Work supported by the DC-IMH project and ITMH graduate certificate program

Work the participants are doing with their agencies	How the DC-IMH cohort and/or grad certificate program supported this work.
<p>Over the last year and a half, we have made sure that all of our staff are trained in a curriculum that centers child attachment. We worked with the University of Washington. They have that parent-child relationship curriculum that we are using, promoting maternal mental health during pregnancy, as promoting first relationships.</p> <p>[My agency] just wanted us to do social service style support for children, families, but we wanted staff to be trained [on attachment] and to be confident in how they were working with the families and promoting their understanding of mental health for families during that time as well.</p>	<p>Through participating in this cohort, really digging into that area of learning (infant and toddler mental health) really helped transform what we were doing at [the agency where I work].</p> <p>Having that knowledge and a real, deeper understanding of infant and toddler mental health really helped me think about the things that we could do.</p>

Work the participants are doing with their agencies	How the DC-IMH cohort and/or grad certificate program supported this work.
<p>Over the last year, through another grant, we were able to give out scholarships to nearly 30 individuals, some of them within the program, so one at every site at least, and then also some community members and other professionals as certified lactation counselors.</p> <p>We did it as a cohort model. We connected people across counties. We built a social media space where they can connect and share resources with one another</p>	<p>I don't know that would have happened without the ITMH background, I don't know that we would have really prioritized that. That was something that I could advocate for and was really excited to see [the lactation] cohort move forward.</p> <p>That was a really important piece and definitely inspired by and informed by the work and the infant mental health cohort. I'm a lactation counselor now, which is pretty cool. I really love that.</p>
<p>The perinatal task force has always had priority areas in that collective action work and mental health across the board for years has been an area of interest. Some of the cohort members were coming to the meetings. Some of the DC-IMH cohort did presentations. H. presented on parent-child interaction therapy. We've had Juniper Tree represented, M. talked about her work. A. has talked about how her knowledge about infant and toddler mental health informs the nurse home visiting work she does.</p> <p>We had a panel discussion, I think almost the entire cohort was there, to really highlight that this community has individuals professionals with infant mental health expertise.</p>	<p>By the connections and the infant mental health cohort, the panel was actually really great. We had some really good discussions and helped our partners see us as people with expertise in infant and toddler mental health.</p>
<p>I started providing mental health counseling services. When we got some additional money, we allocated one day a week of my time to be available for mental health counseling referrals because we had a lot of women who screen for depression or anxiety and don't want to go to the public mental health provider or there. They don't have the right kind of insurance, they have no insurance, or whatever it is. I was able to just offer that as part of my time and we didn't bill, it was just a service, so I was able to carry a caseload during my time there.</p> <p>With my new job, I negotiated my days, I didn't want to work totally full time in that and they were very receptive to letting me spend one day a week doing counseling work at Juniper Tree.</p>	<p>I had already been sort of cooking up this idea and the ITMH grad certificate and extra funding allowed for it.</p>

Work the participants are doing with their agencies	How the DC-IMH cohort and/or grad certificate program supported this work.
<p>I do a lot of work within the larger framework of connecting the many different resources and systems of care to identify and eliminate the gaps and barriers to support, which helps to create policy and procedures that really meet the needs of our community.</p> <p>Within the last year, we have identified a lot of barriers and then problem-solved around those to meet the needs of our children and families.</p>	<p>Without the work I did through the ITMH graduate certificate program and the work I am still doing with the cohort, I do not think infant mental health would even be on the table. I have spent a lot of my last two years educating policy makers about what IMH means and why it is important.</p>
<p>In my previous role, I oversaw therapists that worked in the school based therapy program as well as our day treatment program. Now (with my promotion) I oversee all of youth and family, which is about 40 providers, most of which are therapists. We have specialty programs as well as outpatient care, and programs in all levels of acuity from general outpatient to our most recent program implementation, which is called intensive in-home behavioral health treatment, which is intensive service array that is intended to prevent kids from going into hospitals and residential care.</p>	<p>I think the infant mental health graduate certificate program that I went through, as well as the work I've done with the cohort, played a role in the attaining of my promotion, because I have some specialization now in a niche mark and an age range that really there's a depletion.</p>
<p>Every week we have some sort of case staffing with our staff here in which they bring cases that they're stuck with or that they need extra support on. Specifically what I've done to infuse a lot of what I've learned through the ITMH program is when we're staffing families that have siblings with kids that are birth to five years old. We talk a lot about identifying the signs of postpartum depression. And then also with infants, we talk about sleeping and eating and the disorders that can kind of align with those things and how to best serve a family through attachment. How to promote attachment within families.</p>	<p>Attachment is maybe the foundation of the infant mental health program. And it is, as we know, the foundation of protective factors that keep kids healthy lifelong. And so we do a lot of attachment work and a lot of that was learned and infused from the IT image program that I'm able to bring to over 40 providers that I would not have been able to do before.</p>

Work the participants are doing with their agencies	How the DC-IMH cohort and/or grad certificate program supported this work.
<p>On a larger scale we've contracted with some folks around our community to bring parent groups so that we could start to really focus in on the parent-child dynamic and ways that we haven't in the past. Because we've noticed that that's a service array that had been lacking as well. And we do a ton of referral and collaboration with our partner agency, Juniper Tree for kids, birth to five. And that kind of happens ongoing. And it's a common name around here because we identify the need, well the extreme need for parent-child interaction and parent-child support specifically with kiddos, birth to five in birth to three. And since they're able to provide it really on them heavily, to fill that need.</p>	<p>I don't know if it's possible to measure the benefit of the cohort that went along with the Infant-Toddler Mental Health program. The graduate certificate on its own was wonderful, the training was good. The classes were relevant and applicable to, I think rural areas as well as metropolitan areas and everywhere in between. And that itself was awesome. However, the cohort magnified its efficacy a 100 times. Because what we were able to do was create these lasting bonds in a multi-disciplinary team setting to where now we have what we've really done is reduce the barrier to care for a lot of families in our community. Because instead of having to navigate different processes and guessing how to navigate to get into certain resources. It's now just a phone call. Oh, let me call L.A., she knows how to get that or let me call J. She knows how to make this happen and what it's done for our clients and our community. It's kind of giving them some hope that we can access things, we can do what we need. And it's not going to be as complicated as it once was because of the collaboration that was fostered through this program.</p>
<p>I have changed agencies so that I could leave a role that was more strictly serving children age 4 and up and created a position that allows me to provide services to pregnant and postpartum moms as well as infants and toddlers. In a year I have gone from seeing one infant/toddler and their caregiver to seeing 8-10 infant toddlers, while being able to give family therapy as well as individual therapy to their caretaker as needed. We are continuing to receive referrals for IMH services weekly. We have also created a community for moms to gather and walk outside weekly with other moms, as well as a lactation consultant and mental health consultant.</p>	<p>This program opened my eyes to the lack of resources for IMH in our county. The cohort model gave me the courage and strength to take a professional and personal risk to start a new job that would meet the needs of the underserved IMH population in Douglas County.</p>

Work being done by the extended members of the group

An essential part of the DC-IMH project was connecting to other members of the community who had completed their ITMH graduate certificate, and to mentor others as they began the program. The mentor team reached out to past graduates and current students in the Douglas County area. Four new professionals accepted the invitation to join the sessions and possibly join the participants in their cohort work. A few of the participants were familiar with the new group through their work, and some had never met before.

When connecting to these individuals, it was intriguing, yet not surprising, to hear some of the same struggles and successes in their work with children and families. Each person was excited to connect with the participants in the cohort to further expand the work they were doing. This work was closely connected to the participants' hopes of educating medical professionals in the community about infant, toddler, and maternal health, and bringing the Baby Court program to Douglas County.

Voices of experience

There is importance in spending positive time with infants and moms.

This work can be draining. Participants recommend making it a priority to spend time with infants/toddlers and moms that do not require boundaries from a professional role; this allows for the balance of seeing positive family interactions and not just the difficult interactions service providers may see within the families they work with. These are the things that can fill hearts and keep providers doing the work.

The whole is indeed bigger than the sum of its parts, especially in this field. Participants for this field foster a safe environment to reflect, seek guidance, and process the journey. We are not meant to go at it alone and that is the value of collaboration and partnership.

Cohort Members as Voices of Experience

What training should a new IMH service provider have before entering the field?

Cohort members agree with unanimous confidence: All participants need training in trauma-informed care before and during working in this field. The work of infant and toddler mental health is very delicate, deliberately paced, and vulnerable. Without substantial training in trauma-informed care, the work would be less effective.

Similarly, several participants agree that training in mental health, specifically perinatal care, is highly advantageous when paired with infant and toddler mental health. Going further, when there is a foundational knowledge of early childhood development, the work in this field becomes much more precise. With adequate prerequisite training, the field of infant and toddler mental health has the opportunity to promote family wellness within the first visit and each thereafter.

What barriers have you experienced in your work in this field as a professional or for families with whom you work?

The participants agree that the largest barriers for families accessing infant and toddler mental health are:

- Lack of awareness of available resources.

- Family/generational attitude toward home visitors.
- Lack of trust in the system/organizations.
- Lack of legislative priority placed on IMH.
- Organizational decisionmakers largely unaware of the impact of IMH.
- Stigmatization surrounding mental health.
- Communication and transportation to arrange services.
- The increase of an isolated cultural norm.
- Lack of education for families about the science and biology of postpartum mental health.

Time has been a barrier as well. It takes a long time to meet families where they are. By the time they are ready and willing to accept help, there may be many mental health complications that have developed due to lack of treatment.

What are some things new participants should avoid doing or what advice do you have to avoid burnout?

Pace yourself. Start slow. A provider needs to be able to identify that which fills them and that which drains them. Only then can a true balance be achieved because one will know when to call it a day and when to keep going. Providers are teachers and seed-planters who must not work harder than their families. Instead, they must trust the process. The most effective skill set is one in which the provider can inspire the family to reach their goals and walk alongside them.

One of the most important ways to avoid burnout is to trust the process rather than getting focused on the outcome. Many families may not be ready to take the steps providers want them to. It is difficult to watch parents make poor decisions that negatively impact their children. Participants suggest that as service providers, we must not measure the value of our work by the immediate outcomes, but trust that there will be a positive impact over time.

The participants agree that professional boundaries are critical to this work as they model healthy living as well as ensure that burnout does not occur. Part of setting professional boundaries is maintaining consistent involvement with reflective supervision. The IMH work is an emotional journey for all parties involved. Just as Skovholt and Trotter-Mathison (2011)^{xxvi} emphasize, the practitioner must make space to process their experience and journey with each family. When treatment is complete and the family can now navigate alone, the practitioner must take time to celebrate the accomplishments of the family and grieve the loss of their presence. Families will come and go for the practitioner, and each departure should be honored before the next one begins.

What information do you wish you had known when you entered the field?

The participants wish they would have known that many people within the healthcare industry do not yet know how critical the work of infant and toddler mental health is. There is a substantial learning curve in rural areas and that will require a bit more time and patience on the part of the practitioner, the program developer, and the funders.

Similarly, it would have been helpful to know that the absolute foundation of this work rests on the strength of the practitioner-family relationship. Just as infant and toddler mental health is based on healthy attachment and solid relationships, so, too, is the treatment therein.

Lessons Learned

The DC-IMH Project took place between October 2019 and September 2021, against the backdrop of Covid-19 and unrepresented wildfires in Douglas and surrounding counties. It is a testament to the strength of the group and their dedication of the overall success of the project. The following areas represent lessons learned from the project work in rural communities.

Lesson 1: The Importance of Relational Work in Rural Communities

- Building relationships need to take place over time both as a primary and ongoing focus of the rural infant mental health work.
- Extended relational building causes tension as “not proactive enough.” However, actions taken by the group without relational lead time and consensus checked momentum, causing delays.
- Flexible small (six or less) groupings need to account for individual and community histories. Work to address individual and/or organizational narratives needed to happen in the small controlled group setting of reflective supervision.
- Participants need a sense of psychologically safe where individuals have overlapping and sometimes conflicting roles. Reflective supervision provides safe spaces to resolve conflict.

Lesson 2: Creation of Both Interdisciplinary and Multidisciplinary Practices

- Infant mental health requires interdisciplinary approaches where individuals work across disciplines of 1) family support systems, 2) early care and education, health, mental health, and nutrition, 3) early intervention, and 4) family supports. While the DC-IMH project worked to establish representation from all sectors, missing or uneven representation impacts momentum.
- Individuals must self-select participation and have a sense of agency in the work. Different roles and responsibilities within or across agencies can create power dynamics. Intentional structures focus on equalizing voice and contributions are required, as are member checks for ongoing agreement.
- Working towards a multidisciplinary coordinated system of care for diverse rural communities required mapping of individual and organizational connections. Activities reveal both strength of connections and silos of organizational information or bias based on narratives of competing resources.

Lesson 3: Strong Place-based Work Acknowledges the Complex Relationships in Rural Communities

- Design of projects navigate both historic and current dynamics of rural communities and their culture. Complex place-based relationships in rural communities, require transitions from organizational roles and responsibilities into shared space collaborations and meaning making.
- Projects need both leadership in the community and external supports to address issues of transparency between agencies to mitigate issues of perceived organizational power or preference.
- Research and implementation require leadership in the community to facilitate work.

Lesson 4: Sustained and Transparent Coordination is required for Systems Change

- Successful efforts to create sustained change require coordinated efforts and transparency reveals gaps and duplication of services. Coordination requires ongoing member checks for agreement as individual and organizational scopes-of-work can change over time.
- Understanding the tension of resource competition or perceived resource completion when faced with overwhelming need in a community. Working from beliefs of organizational duplication of work to concepts of collaboration with similar goals, thus focusing on supporting each other, rather than competition.
- Needs to develop unified understanding of the group's goals. The importance of slowing down to allow processes to unfold. Historic beliefs about individuals and communities require time to re-orient to build trust and new understandings.

Resources

Wonderful resources can be found at the [Zero to Three](#) website.

For Early Childhood and Home Visitors

Barbre, J. & Anderson, I. (2021). *Supporting Children's Mental Health and Wellbeing: A Strength-based Approach for Early Childhood Educators*. Releaf Press, MN.

Region X (2019). *Reflective Supervision Guidelines: Best Practice Guidelines for Reflective Supervision/Consultation* Retrieved from <https://macmh.org/programs/iec/macmh-iec-professional-endorsement/guidelines-reflective-supervision/>

Summers, S. J., & Chazan-Cohen, R. (2012). *Understanding Early Childhood Mental Health: A Practical Guide for Professionals*. Brookes Publishing Company. PO Box 10624, Baltimore, MD 21285.

Zero to Three (2021). *Infant and Early Childhood Mental Health*. Retrieved from <https://www.zerotothree.org/espanol/infant-and-early-childhood-mental-health>

For Mental Health Clinicians

Carter, A. S., & DelCarmen-Wiggins, R. (Eds.). (2019). *The Oxford Handbook of Infant, Toddler, and Preschool Mental Health Assessment*. Oxford Library of Psychology.

Clark, R., Tluczek, A., Moore, E. C., & Evenson, A. L. (2019). Theoretical and empirical foundations for early relationship assessment in evaluating infant and toddler mental health.

Kristie Brandt, C. N. M., Perry, B. D., Stephen Seligman, D. M. H., & Tronick, E. (Eds.). (2013). *Infant and early childhood mental health: Core concepts and clinical practice*. American Psychiatric Pub.

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Appendix A: Portland State University Infant Toddler Mental Health Programs Framework

Term 1 5 credits	<ul style="list-style-type: none">• CI 592 Dynamic Models of Infant Toddler Development (<i>3 credits</i>)• SPED 507 Professionalism in ITMH I (<i>2 credits</i>)
Term 2 5 credits	<ul style="list-style-type: none">• COUN 597 Strengths, Risk Factors, and Disturbance in Infants Toddlers and Their Families (<i>3 credits</i>)• COUN 520 Collaborative Partners to Support Infants Toddlers and their Families I (<i>1 credit</i>)• SPED 507 Professionalism in ITMH II (<i>1 credit</i>)
Term 3 5 credits	<ul style="list-style-type: none">• SPED 594 Assessment Methods and Classification in Infant Mental Health (<i>3 credits</i>)• COUN 520 Collaborative Partners to Support Infants Toddlers and their Families II (<i>2 credits</i>)
Term 4 5 credits	<ul style="list-style-type: none">• SPED 597 Prevention and Intervention in ITMH (<i>3 credits</i>)• SPED 507 Professionalism in ITMH III (<i>2 credits</i>)

Appendix B: Portland State University Infant Toddler Mental Health Graduate Certificate Course Descriptions

SPED 507 Professionalism in ITMH (5 credits over 3 terms)

Professional Development in Infant Toddler Mental Health occurs during three of the four quarters of the ITMH certificate program. This course focuses on the roles and challenges of being an infant mental health practitioner. We will examine ethical and boundary issues within the infant mental health field. We will also use self-reflection and dialogue with peers to understand ourselves better as infant mental health practitioners. Participants will conduct an interview with a practitioner in the field and reflect on the encounter to further the understanding of material presented in the content course. During this quarter, typical development and its variations (cultural, developmental, ethnic, SES, diagnostic status, etc.) in infants, toddlers and their families and the contexts in which they live will be explored.

ECED 585 Dynamic Models of Infant/Toddler Development (3 credits)

This course provides information on typical infant/toddler mental health development and strategies for working with young children and their families within a culturally sensitive context. Content includes prenatal, perinatal and postnatal development, brain development as well as theories of development, including attachment, resiliency, and self-regulation. Course reading and handouts reflect recommended practices across disciplines when working with young children and their families. Learn to gather and document intake information from families of various ethnic and socioeconomic backgrounds. Become a link for families to community resources.

COUN 520 Development and Utilization of Collaborative Partnerships to Support Infants, Toddlers, and Their Families (3 credits)

Gain understanding of the family and cultural contexts in which child development occurs. Identify cultural, political, and socioeconomic biases within which mainstream research and theory have emerged. Understand and apply system-of-care concepts and values as they engage in relationship-based consultation. Content includes information about the roles and knowledge bases of specific disciplines as they apply to infant/toddler social/emotional development (e.g., child care, pediatrics, nursing, early intervention, mental health, allied health, child welfare). Learn about the roles and knowledge bases of informal family and community supports as they apply to infant/toddler social/emotional development. Gain knowledge and training related to infant/toddler key transitions from one setting to the next (e.g., from home to community child care, child care to preschool).

COUN 597 Strengths and Risk Factors (3 credits)

Focus on infants, toddlers and their families, and how they cope successfully with life tasks and external stressors. Examine what happens when coping breaks down and problems emerge in families with young children. Be able to: Identify relevant strengths and resiliency factors for infants, toddlers, and their families. Understand developmentally relevant risk factors, especially parental mental health issues, and their potential impact on infants, toddlers, and their families. Gain knowledge of major forms of psychopathology within infant/toddler mental health

SPED 594 Assessment Methods (3 credits)

Develop knowledge and skills to complete the assessment process through multiple sources of information within a culturally relevant context. Topics include selection of tools and methods for information collection, methods for screening and assessment, and use of classification systems.

SPED 595 Prevention and Intervention (3 credits)

Develop an appreciation of the concepts of early intervention and prevention. Examine the range of interventions used in the field of infant mental health. Emphasis is on the importance of treating infants and toddlers in the context of their families and communities. Discuss intervention strategies, including those targeted at children with psychosocial/relational and developmental disturbances as well as those determined to be at risk. Review international, national, and regional programs, established and pilot, in early intervention and prevention. Improve ability to assess and critically evaluate the current science around treatment efficacy of various interventions.

Appendix C: Eco-Map Activity Instructions

Materials:

- poster board or large paper
- markers & pens

Instructions: Creating your Ecomap - each participant will create their own.

1. Draw a large circle in the center. In this circle describe each person in which you interact with or who has a strong influence on you or your career. Include people you work with as well as members of your family.
2. Identify the quality of the relationship between each individual through the use of lines:
 - (add graphic) a solid or thick line represents an important, strong, or positive connection.
 - (add graphic) a broken line represents a tenuous or weak connection.
 - (add graphic) lines with crosses through them indicate a stressful relationship.
 - (add graphic) Arrows along the line point towards the direction or flow of resources.
3. Identify any significant extended family relationships or important relationships and the quality of these relationships currently using the lines outlined above. Draw figures, emojis, draw buildings. Thought bubbles, - try to not use words at first. Focus on emotions.
4. Identify the social and environmental systems which impact you. For example: links to school, work, faith organization, welfare support agency, child protection services, youth justice, department of corrections etc. Then draw a line to represent the quality of the relationship between you and the environmental system that has been identified as above.
5. Connections can be drawn to your circle as a whole or to one individual within the circle.

Partner Sharing: Each participant partners with another participant to share their Ecomap.

1. Choose who will go first.
2. Briefly (one minute) share a story of your work with your partner. This could be a moment in time or something that unfolded over time. It could have happened recently, or still be in progress. The important thing is that this is a story that stands out to you as one in which you felt there was some forward movement in a family meeting their goals
3. “Walk” your partner through your Ecomap. As you do, add any details that seem important. Your partner is encouraged to ask questions for clarification.
4. Switch your roles.

Eco-Map Discussion

As the participants completed their Eco-Maps, allow time for each person explore each other's maps. After reviewing and discussing the Eco-Maps, invite participants back to 1) discuss their own connections and to 2) discuss the themes that emerged.

- What is already in the community?
- Where do we need to build?
- Where are the gaps for community support?

Detailed questions building discussion

- Thinking non-traditionally and thinking about community:
 - Who is in contact with families that we miss?
 - Who are their relational experts?
 - Where do they go and who are they interacting with there?
- What are you willing to give up as far as your thoughts about traditional ways to find new spaces for connections?

Appendix D: Hopes And Dreams Activity

Instructions: To build a sense of community, the closing activity focused on writing out the hopes and dreams of the cohort.

The Hopes and Dreams became a touch point and a few were shared and discussed at subsequent meetings.

Hopes (Balloons)	Dreams (Stars)
<ul style="list-style-type: none"> • We continue to HOLD our families in mind in our hearts together • To develop increased strengths and trust as I move through a new development of skills • To find a schedule that works for my personal self-care & my family needs. To develop a greater understanding of what DC families need to be successful and provide that opportunity. • I am hopeful that we will have a rich and meaningful learning experience over the next two years and that many children and families will benefit as a result. • My hope is that we build a network that captures every child and family in need to prevent risk and greatly enhance the quality of life for our community. • Growing my knowledge, narrowing my vision • To support others to their success. • Continued growth and collaboration. • I hope to learn to integrate the IMH focus into our training so that advocates understand the possible sources of behaviors in children of any age. • To gain knowledge and connections to better serve infants and toddlers along with their families to improve our communities. • A strong system that supports our community • Make a difference in my community surrounding the field of IMH, become an advocate for the mental health of toddlers/infants everywhere! • I hope to increase my knowledge and achieve a greater understanding of IMH to become a strong resource for others in my community and strong support for youth and families. • Building more connections with community partners and working together to create more services. • New personal and professional insights that enhance the quality of work/services/relationships with partners and families. 	<ul style="list-style-type: none"> • Making connections and opportunities for learning and growth. • Relationships/connections with other agencies and individuals. • Connections being made. • Networking and building relationships. • Networking and making connections with providers and agencies in Douglas County - to better understand their services and be able to make direct referrals to real people. • Expanding my knowledge about series and resources in the community. • I am excited to learn about new avenues to support youth and families. • To make a difference. • A new depth of relationships among the participants will be created. • All coming together today, new friends. • To connect with others and develop relationships to push us forward. • Collaboration • Building new or stronger relationships with professionals about children and families. • I'm excited to build relationships with community partners. • Connections. • To meet everyone and hear your thoughts about families.

Appendix E: Journey Map Activities

Journey Map Activity

A Journey Map is a visual representation of an individual's process to where they are currently and what they would like to accomplish in the future in their professional and/or personal lives. It begins by the individual creating a timeline that includes significant milestones of their journey and what they are hoping to achieve as they continue their journey. This process includes the actions, mindsets, and emotions that accompany each step of the journey.

Offer participants a variety of materials. Explain that the purpose of the Journey Map is to map your professional journey.

Once the maps are complete, you're the following questions to have the participants reflect in pairs.

- How are you applying content of the certificate program in your practice?
- What seems to be changing or what have you noticed?
- Where do you see yourself going with your work in IMH?

After some time for reflection, the participants returned to a full group conversation guided by the following leading questions:

- What are the barriers and/or gaps to Oregon state policy to IMH?
- What agencies should we bring in to fill in those gaps?
- As resources grow, how do we become proactive rather than reactive - to be resource-rich rather than scarce?
- What are you seeing that will be helpful to move the work forward?
- Think of one group that would be pivotal to help you make a change.
- Who is missing from this room who could scaffold and build on your work?
- Where are the untraditional places/people that interact with mothers and families?

Journey Maps:



Quotes from Conversation:

“We focus on how to get infants to a safe place but we don’t focus on how to get them with families and the services they need. We work with five and six-year-olds that have witnessed or been a victim all their lives. We start with ‘How do we fix this child’ not ‘How do we HELP this child’ or ‘How do we follow the trail to make sure we stop this situation?’”

“There seems to be a disconnect from the medical system – how can we get that education piece of what is IMH to them?”

“There is a huge need for teaching parenting skills, a demand for understanding, people want to learn how to understand a two-year-old, how to be a good parent.”

“Workers who come in and remove infants do not have the training/knowledge/education around IMH, it causes a ripple effect. Could we have more training for child welfare workers, families, and parents? How do we help them through the processes of grief, loss, and growth so they do not repeat their actions? Can we train foster families about how to work with children that have experienced trauma?”

“Families have a fear of DHS, they worry that if they talk to them they will lose their children. Everyone who works with that mother (ob-gyn, pediatricians) needs to be educated in IMH and maternal mental health.”

“ There is no work being done around the trauma of the children’s experiences. It is all focused on the parents but what happens to the child that goes through 10 foster homes?”

“How do we make it so that medical professionals know what to do, who to turn to, what resources are available, or how to contact them? It could be as simple as a single form.”

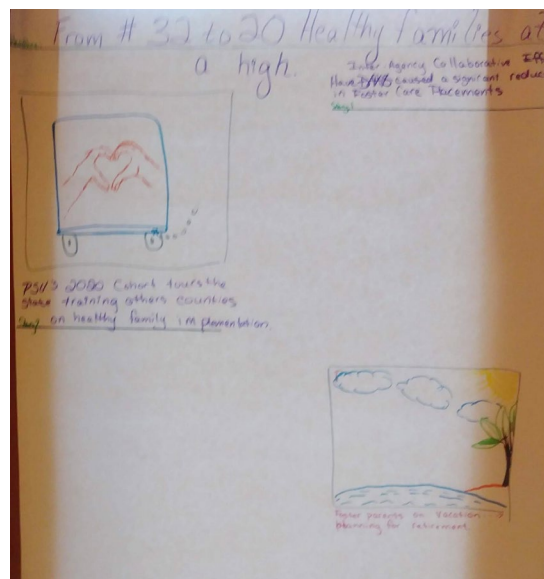
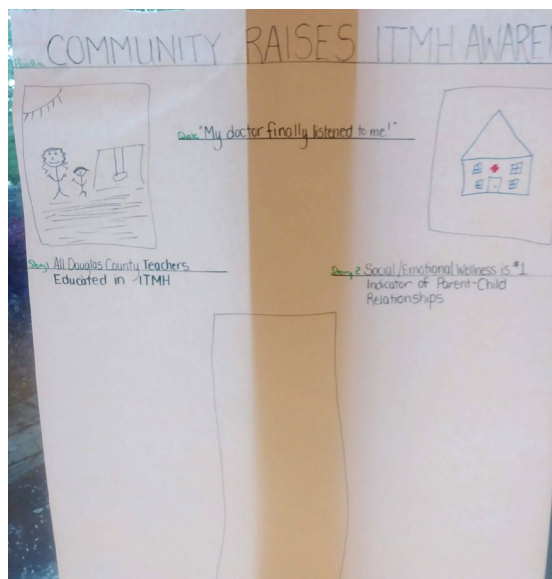
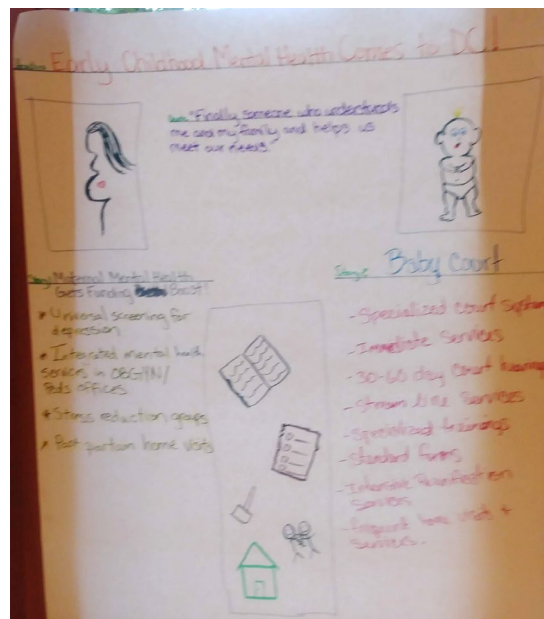
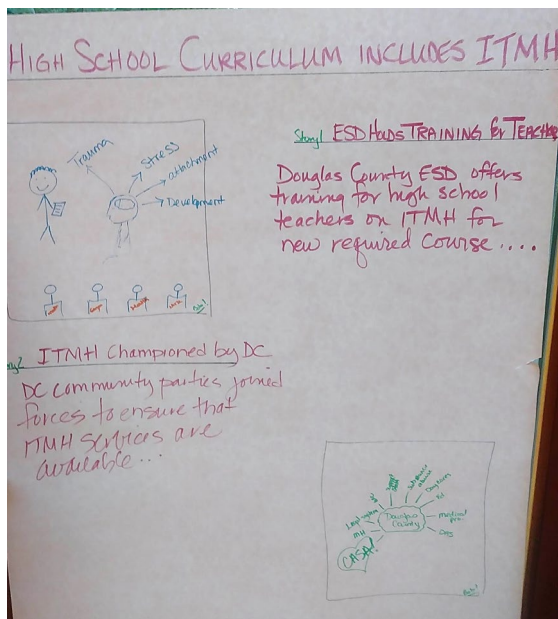
Appendix F: What's My Headline?

In this activity, small groups work to develop a headline of events that they wish to achieve collaboratively over time. For the DC-IMH cohort, we asked participants to create a headline for 5-years in the future. The activity served to also lay the steps for the first items on a future 5-year strategic plan.

Headline actives include: 1) the main headline, 2) a secondary headline, 3) 2-3 'quotes' from 'people' commenting on the success of the project, 4) 2-3 boxes that represent 'photos', 5) and a key paragraph describing events that is under the main headline outlining activities.

Breakout into small groups, using the What My Headline Template, create a e-News page headline of what IMH look like in Douglas County in five year – think about how you might want to impact and evolve

- Possible areas for reflection are....
 - **Promotion:** Services that recognize the central importance of early relationships on brain development, learning and the emotional and social well-being of all young children. These services include a focus on positive parent-child and primary caregiver relationships within the home, child development settings and other service settings for young children and their families.
 - **Preventive/ Intervention:** Services that mitigate effects of risk and stress and address potential early relationship challenges or vulnerabilities that have a documented impact on early development. Specific intervention strategies are designed to nurture mutually satisfying parent child relationships and prevent the progression of further difficulties. Health and developmental vulnerabilities; parenting difficulties; domestic violence, family discord and other major child and family stressors may warrant the delivery of preventive intervention services in a variety of settings.
 - **Treatment:** Services that target children in distress or with clear symptoms indicating a mental health disorder. They address attachment and relationships problems and the interplay between the child, parent and other significant caregivers that jeopardizes early mental health and early emotional and social development. Specialized early mental health treatment services focus on the parent-child dyad and are designed to improve child and family functioning and the mental health of the child, parents, and other primary caregivers



Five-Year Collective Roadmap Activity

To keep the focus on how the participants were envisioning the future of IMH in their community, the mentor team asked them to add their ideas to a Collective Roadmap. Each was to add their hopes for the future along the timeline as well as what the necessary steps might be to obtain each goal. The roadmap was to be a working document that we would revisit and update.

DC-IMH 5-year Collective Roadmap

2019

- Develop IMH Task Force
- Raising Awareness/Community Partner Trainings
- Train HV & community family workers for IMH foundations
- In-home foster parent training
- Educating community partners
- Agencies create a plan to communicate and collaborate
- Provide promotion funding for Take Root and Parenting

January 2020

- All pediatricians & OB-GYNs trained in IMH
- Ed & OEA community partners
- IMH Plan for community education established
- Offer transition into kindergarten for all families
- Training community partners/program development

July 2020

- Increase in IMH providers
- Overcome transportation barriers

January 2021

- Robust family therapy and support financially available
- OEA revises curriculum to include IMH

July 2021

- Funding, community buy-in, policy, and the procedure is established

January 2022

- All agencies participating in Take Route parenting class
- Training of teachers in IMH

July 2022

- Implementation in monitoring data collection feedback
- Community HUBs in all communities

January 2023

- High School Curriculum includes IMH

July 2023

- Community raises IMH awareness
- Continuing monitoring maintenance, finalize protocol and processes

Appendix G: No Small Matter Screening

An additional goal of the group was to take leadership roles in the local IMH community. The participants had several different ideas of how to do this. Some of the ideas presented by the participants in the past included increasing public awareness. A movement happening at that time in Oregon was the documentary *No Small Matter*. The mentor team ordered access to the documentary to share with the participants as a consideration of a possible public awareness event.^{xxvii}

No Small Matter is a feature-length documentary film and national engagement campaign that brings public attention to the fact that millions of American children are still not getting the access to early childhood care and education programs they need by sharing powerful stories and stunning truths about the human capacity for early intelligence and the potential for quality early care and education to benefit America's social and economic future. This multifaceted project reveals how our country is raising its youngest citizens, why making the most of this time in their lives is so crucial, and most importantly, what we can do to change the perception of when learning begins. The first major theatrical documentary to tackle this topic, *No Small Matter* is designed to kick-start the public conversation about early care and education. The ultimate goal: to produce an entertaining, accessible, and inspiring film that redefines the audience's understanding of the issue and helps drive it to the top of the political agenda^{xxviii}.

While introducing the film, and the intention behind the film, it was noted that in the conversations around early childhood care and education, early mental health was often left off the table. The mentor team invited the participants to think about how they could bring their voices and the work that they do to the conversation as they watched the film.

- What parts of the film were strong, what was missing?
- With other Douglas County entities promoting this film locally to early childhood care and education providers and families, where could we join their efforts?
- Who else can we partner with to amplify the message of the film to additional stakeholders?
- In what ways could we use this film to connect with the participants' 5-year vision?
- How do we support the work already being done around this film in Douglas County without reinventing the wheel or duplicating efforts?
- How do we see our experiences impacting the collective effort around this topic?
- How might we build on our collective action?
- How do we bring people in?
- What topics do we want to introduce?
- How do we bring a strengths-based perspective that deepens the conversation instead of replicating what we already know?

After watching the film, the participants met in small groups to discuss before heading into a whole group discussion. After meeting for 15 minutes, the group came back together to discuss. The whole group discussion began by addressing the questions;

How do we bring the infant mental health lens to the events that will happen in the community? and What bubbled up in your conversations as the important points we need to address?

- *“There is such a huge need locally to bring public awareness to what infant mental health is, even among agencies that support families and children, and the medical profession. If they don’t know what it is, how do we get them to fund it?”*
- *“[The lack of knowledge] about how development impacts children as they grow is a crisis, it needs to be addressed in a big way or it is going to implode.”*
- *“It is difficult to even talk about because there is such a stigma about mental health.”*

What community events can we get involved with to have a public service announcement and get the word out?

- *“[The issues (addiction, poverty, poor mental health)] are so generational in this area. How do we bring awareness? what we are doing is obviously not working.”*
- *“One thing that stuck out to me in the film with the parent who said she had thought of herself as a good mom and that she already knew how to parent, but now she realized that she did not know what she did not know.”*
- *“Parents might be resistant but they always have their kid’s best interests at heart.”*
- *“If there is a stigma connected with the term “mental health” why not just change the language to “early healthy bonding and attachment”? What we want parents to know is how to bond with their children in a way that creates healthy brain development.”*

How can we build on the growth we have seen in the last two years such as the conversations around trauma-informed language in schools and PCIT?

- *“One issue I had about the movie is that it just focused on getting children in child care, it wasn’t focused as much on good parenting. I wish they would have given more light to how amazing that dad was at letting him help fix the car, be a part of their lives and they both learned how to do time outs and expectations explaining that their kid needed energy like those are things that families would come in my office don’t know how to do they just don’t they don’t know how to bring their kid into their life.”*
- *“How might we be able to connect to the new George Fox residency program in Douglas County?”*

Appendix H: Global Café

Information pulled from *The World Café* - <http://www.theworldcafe.com/key-concepts-resources/world-cafe-method/>

The Global Café methodology is a simple, effective, and flexible format for hosting large group dialogue. Each element of the method has a specific purpose and corresponds to one or more of the design principles.

- 1) Set the Context** - Pay attention to the reason you are bringing people together, and what you want to achieve. Knowing the purpose and parameters of your meeting enables you to consider and choose the most important elements to realize your goals: e.g. who should be part of the conversation, what themes or questions will be most pertinent, what sorts of harvest will be more useful, etc..
- 2) Create Hospitable Space** - Café hosts around the world emphasize the power and importance of creating a hospitable space—one that feels safe and inviting. When people feel comfortable to be themselves, they do their most creative thinking, speaking, and listening. In particular, consider how your invitation and your physical set-up contribute to creating a welcoming atmosphere.
- 3) Explore Questions that Matter** - Knowledge emerges in response to compelling questions. Find questions that are relevant to the real-life concerns of the group. Powerful questions that “travel well” help attract collective energy, insight, and action as they move throughout a system. Depending on the timeframe available and your objectives, your Café may explore a single question or use a progressively deeper line of inquiry through several conversational rounds.
- 4) Encourage Everyone’s Contribution** - As leaders we are increasingly aware of the importance of participation, but most people don’t only want to participate, they want to actively contribute to making a difference. It is important to encourage everyone in your meeting to contribute their ideas and perspectives, while also allowing anyone who wants to participate by simply listening to do so.
- 5) Connect Diverse Perspectives** - The opportunity to move between tables, meet new people, actively contribute your thinking, and link the essence of your discoveries to ever-widening circles of thought is one of the distinguishing characteristics of the Café. As participants carry key ideas or themes to new tables, they exchange perspectives, greatly enriching the possibility for surprising new insights.
- 6) Listen together for Patterns and Insights** - Listening is a gift we give to one another. The quality of our listening is perhaps the most important factor determining the success of a Café. Through practicing shared listening and paying attention to themes, patterns and insights, we begin to sense a connection to the larger whole. Encourage people to listen for what is not being spoken along with what is being shared.
- 7) Share Collective Discoveries** - Conversations held at one table reflect a pattern of wholeness that connects with the conversations at the other tables. The last phase of the Café, often called the “harvest,” involves making this pattern of wholeness visible to everyone in a large group conversation. Invite a few minutes of silent reflection on the patterns, themes and deeper questions experienced in the small group conversations and call

them out to share with the larger group. Make sure you have a way to capture the harvest – working with a graphic recorder is recommended.

World Café can be modified to meet a wide variety of needs. Specifics of context, numbers, purpose, location, and other circumstances are factored into each event’s unique invitation, design, and question choice, but the following five components comprise the basic model:

1. **Setting:** Create a “special” environment, most often modeled after a café, i.e. small round tables covered with a checkered or white linen tablecloth, butcher block paper, colored pens, a vase of flowers, and optional “talking stick” item. There should be four chairs at each table (optimally) – and no more than five.
2. **Welcome and Introduction:** The host begins with a warm welcome and an introduction to the World Café process, setting the context, sharing the Cafe etiquette, and putting participants at ease.
3. **Small-Group Rounds:** The process begins with the first of three or more twenty-minute rounds of conversation for small groups of four (five maximum) people seated around a table. At the end of the twenty minutes, each member of the group moves to a different new table. They may or may not choose to leave one person as the “table host” for the next round, who welcomes the next group and briefly fills them in on what happened in the previous round.

Appendix I: Action Plan

Action Planning Template

Project:	Who is working on this project? Would you have outside partners? Who?				
Main Goals of the Project - What will have happened when project is complete a) b) c)					
Break down each task that needs to be accomplished to meet the goal	Who will help for each tasks	What/Who needs to be part of the communication loop for this part of the project?	Start Date	End Date	Check-in at Meetings for Progress
Goal (a, b, c):					
Resources Needed					
Resources Needed					
Resources Needed					

Appendix J: Info Graphic

Info graphics are visual representation of idea where a large amount of complex information can be simplified into a structure that is quick and easy to understand. Info graphics always start with research of the selected topic and the careful curation of information to share. Factual information is cited in the info graphic for others to verify its source.

A rough visual sketch of the graphic is helpful to ‘play’ with the ideas presented. Organization and design are critically important in conveying data and information to others. Questions to ask include:

1. Which information, facts, and data are essential to include? Which aren’t?
2. What colors and layout works best in sharing the information?
3. What graphs and graphics best convey information and data to the viewer?
4. What is the order, or flow, of information?

There are many info graphic software programs that can be used to create the graphic.

Using info graphics helps team to clarify their message. Collaborative design supports a shared idea of the project concepts.

End Notes

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- ⁱ Zero to Three (2021). Infant and Early Childhood Mental Health. Retrieved from <https://www.zerotothree.org/espanol/infant-and-early-childhood-mental-health>
- ⁱⁱ - Parlakian & Seibel, 2002
- ⁱⁱⁱ Center for Disease Control, 2021 retrieved from <https://www.mcleanhospital.org/essential/yes-there-big-difference-between-mental-health-and-mental-illness>
- ^{iv} Barbre, J. & Anderson, I. (2021). Supporting Children's Mental Health and Wellbeing
- ^v Zero to Three: Making it Happen, 2012. < www.zerotothree.org/public-policy/federal-policy/early-child-mental-health-final-singles.pdf> (Accessed April 22, 2016). [Ref list]
- ^{vi} Reflective Supervision Guidelines: Best Practice Guidelines For Reflective Supervision/Consultation Retrieved from <https://macmh.org/programs/iec/macmh-iec-professional-endorsement/guidelines-reflective-supervision/>
- ^{vii} Duncan and Hubble, 2000
- ^{viii} Morgan and Ziglio, 2007
- ^{ix} Thelen & Ulrich, 1991
- ^x Alice C. Schermerhorn, E. Mark Cummings, in [Advances in Child Development and Behavior](#), 2008 - <https://www.sciencedirect.com/topics/psychology/dynamic-system-theory>
- ^{xi} Summers & Chazan-Cohen, 2012
- ^{xii} <https://stateofbabies.org/wp-content/uploads/2020/06/State-of-Babies-2020-Full-Yearbook-061820.pdf>
- ^{xiii} Sorte, Daeschel & Amador, 2017, p. 401
- ^{xiv} Barbre & Anderson, 2021
- ^{xv} (<https://thousanddays.org/why-1000-days/>)
- ^{xvi} Going the Distance: Promoting Rural Participation in the Professional Development of Infant Mental Health Workers 11/08/2019 | [Articles](#), [World in WAIMH](#) | Reams, R. & Light, P.
- ^{xvii} <https://www.tfff.org/about-us/what-we-believe>
- ^{xviii} McGuinness <https://www.youthcollaboratory.org/resource/drawing-strengths-rural-communities-module-1>
- ^{xix} Stewart, 2018
- ^{xx} *ibid*
- ^{xxi} *ibid*
- ^{xxii} Reflective Supervision Guidelines- <https://macmh.org/programs/iec/macmh-iec-professional-endorsement/guidelines-reflective-supervision/>
- ^{xxiii} Shahmoon-Shanok 1991
- ^{xxiv} Summers & Chazan-Cohen, 2012.
- ^{xxv} <https://www.nosmallmatter.com>
- ^{xxvi} Skovholt and Trotter-Mathison, 2011
- ^{xxvii} <https://www.nosmallmatter.com>
- ^{xxviii} <https://www.nosmallmatter.com/about-the-film>

