CENTER FOR THE SOCIAL POLICY (CSSP)

EARLY RELATIONAL HEALTH NATIONAL SURVEY

What We're Learning From the Field

MAY 2020

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ABOUT CSSP

The Center for the Study of Social Policy works to achieve a racially, economically, and socially just society in which all children and families thrive. We do this by advocating with and for children, youth, and families marginalized by public policies and institutional practices.

ACKNOWLEDGEMENTS

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GLOSSARY

ACEs: Adverse childhood experiences
ASQ: Ages and Stages Questionnaire
CSSP: Center for the Study of Social Policy
DIR: Developmental, Individual Difference and Relationship-Based
DULCE: Developmental Understanding and Legal Collaboration for Everyone
EB: Evidence-based
EC-LINC: Early Childhood Learning and Innovation Network of Communities
ECCS: Early Childhood Comprehensive Systems
ECE: Early care and education
EHS: Early Head Start
ELN: Early Learning Nation
ERH: Early relational health
FAN: Facilitating Attuned Interactions
FIND: Filming Interactions to Nurture Development
HFA: Healthy Families America
HMG: Help Me Grow
HV: Home Visiting
IECMH: Infant, early childhood mental health
IECMHC: Infant, early childhood mental health consultation
IMH: Infant mental health
NCIT: National Collaborative on Infants and Toddlers
NFP: Nurse Family Partnership
PAT: Parents as Teachers
PCA: Prevent Child Abuse America
ROR: Reach Out and Read
SDOH: Social determinants of health

INTRODUCTION

Early relational health (ERH) is a dynamic concept that has emerged in the last few years from leaders in pediatrics, public health, early childhood community systems, early childhood mental health, and child health policy. The term "early relational health" (along with the companion frame of "foundational relationships") encompasses a growing body of science pointing to the critical importance of early relationships to future child and family well-being. The use of Early Relational Health as a concept is intended to (1) communicate the essential and foundational nature of early relationships; (2) deliberately link the roles of strengthening healthy early relationships to the fields of child health care, public health, and broader community early childhood systems; and (3) move the ideas into operational strategies that positively impact young children and their caregivers. Further, as early relational health and the companion framing of foundational relationships become more visible and salient, early childhood system-building efforts in communities can align the relational focus across all sectors including pediatric health care, public health services, early care and education, child welfare, and family support services (including home visiting and others).

The importance of heathy relationships in the first 1,000 days of a child's life is based in scientific evidence. Early relational health emerges from complex interpersonal interactions between young children (birth – age 3) and caregivers (parents, extended families, ECE providers, etc.). In brief, foundational relationships have many of the following characteristics: begin before birth; essential and core to our evolved biology; dyadic, positive, and nurturing; consistent, safe, and secure; variable across cultures; experienced with a range of individuals, and observable.

Many studies in public health, social policy, and child health have shown that there are multiple contextual, structural, historical, and resource threats to early relational health. Creating and sustaining such foundational relationships can be affected by the health, mental health and wellbeing of caregivers; punitive employment policies and patterns that impact parent's time and ability to care for their children; poverty that strains a family's ability to focus sufficiently on caregiving when attention is focused on securing basic income, affordable housing, and food; and structural inequalities that reduce access to health care, support services, and treatment. These structural and systemic

impediments to a caregiver's ability to care for their children necessitate policy and advocacy attention. At the same time, we are learning about the power of early relational health to shape health, resilience and child well-being .

With the generous support of the Perigee Fund, the Center for the Study of Social Policy, under the leadership of David W. Willis, MD, Senior Fellow, has begun work to accelerate the framing, understanding, and application of early relational health principles and practices among key stakeholders and networks in the fields of pediatrics, mental health, family support, early childhood systems-building, as well as with parents. CSSP's first year of this work has been focused on establishing a definition, framing, and core principles/ concepts of early relational health for use and translation in action within pediatrics and child health and potentially across the broader early childhood field. We have begun to engage prominent stakeholder networks and initiatives to test the strength of the ideas and then develop a plan of action. Early in 2020, we conducted a national web-based survey across early childhood health and program providers, early childhood systems builders, and communities. The purpose of the survey was to get a better sense of current ERH-related activities, best practices, policy needs, and interests across early childhood sectors and systems. This brief is a summary of the key findings and opinions from a broad array of early childhood respondents that points to the needs and opportunities to further advance an early relational health agenda.

SURVEY METHODOLOGY

The team created a 20-question survey that was distributed widely across CSSP's network of partners and key early childhood system collaborators and stakeholder groups (Appendix A). Among the national organizations and program offices that helped disseminate the survey were Early Childhood Comprehensive Systems Impact, HealthySteps, Reach Out and Read, Early Childhood-Learning and Innovation Network of Communities (EC-LINC), BUILD, Help Me Grow, Zero to Three (members channel), Healthy Families America/ PCA, Parents as Teachers , Nurse Family Partnership, ParentChild+ Network, Alliance for the Advancement of Infant Mental Health (AAIMH), Early Learning Nation, Capita, the StriveTogether, and Strengthening Families. The survey was launched Dec 23rd and remained open online until January 23rd, with the robust participation of 584 participants, whose responses generated the content of this report.

"I took the survey as soon as I saw it online! The questions and content are not only interesting...they will affirm so much of what, how, and who we are as folks working in the field. I was particularly impressed with the scope of the survey and the big circle it drew around ALL of us as the human family!"

Catherine J. Martin, LPC, ACS

The survey captured a broad array of respondents from 46 states and the District of Columbia representing many sectors of the early childhood field, with the greatest representation from health care/public health, home visiting, and early learning/early care and education. Among the participants, 41% participants noted themselves to be part of early childhood systems or networks (e.g., EC-LINC, ECCS, HMG, NCIT, BUILD, ELN, other EC systems). Sixteen different networks were represented with much overlap, and some individuals also noted being a part of the child welfare, Head Start, and other community coalitions. The survey was not designed to capture parents' perspectives, however, focus groups conducted as

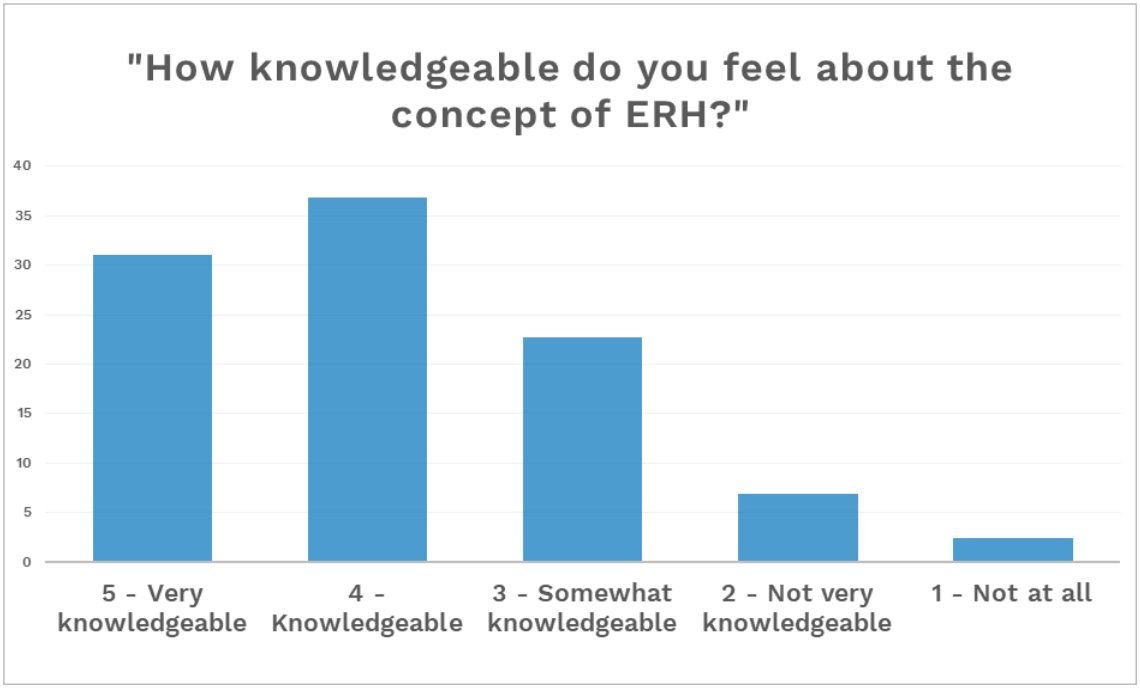
Respondents report working in the field

- 23% Health care/public health
- 19% Home visiting
- 19% Early learning / ECE
- 10% Early childhood community systems
- 7% Mental Health, IECMH
- 6% Family Support
- 16% Others (child welfare, Part C, higher education, trainers, etc.)

SURVEY FINDINGS

Across survey respondents, there is broad understanding of the term "early relational health" and general agreement with a proposed definition.

Before defining early relational health, we asked the participants to first rate on a Likert Scale "How knowledgeable do you feel you are about the concept of ERH?"



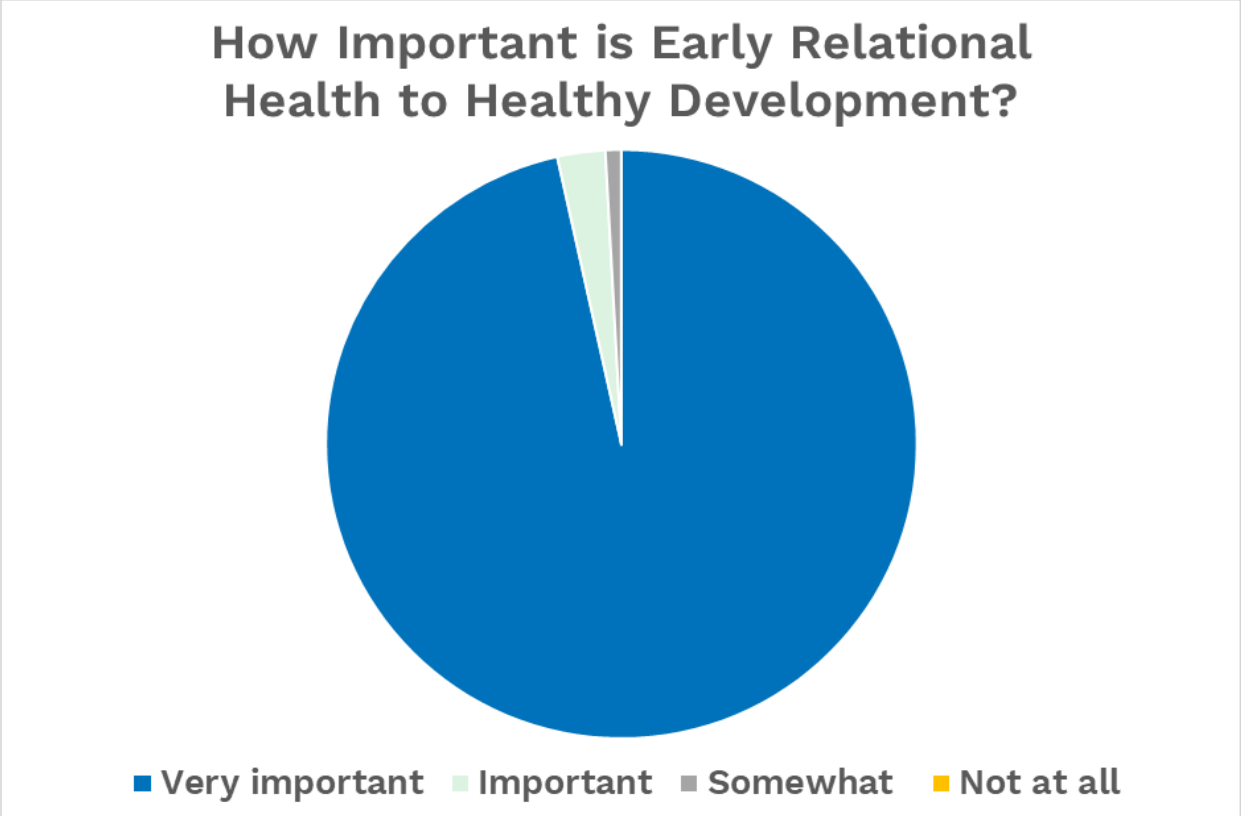
Similarly, when asked to respond on a Likert Scale to the following draft definition, 65% of those responding said this definition fits well (ranked, 5) and 26% reported that the definition ranked (4) on the scale.

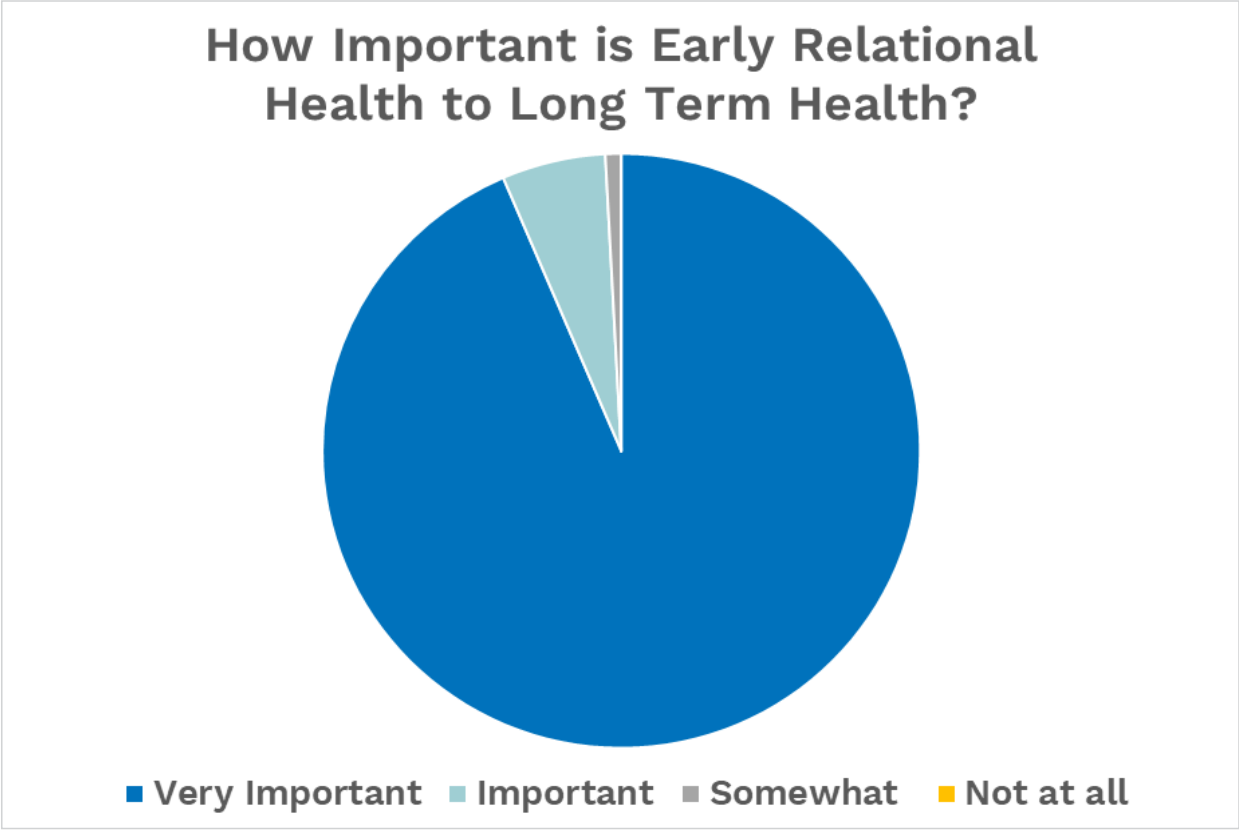
WORKING DEFINITION OF EARLY RELATIONAL HEALTH

Early relational health describes the positive, stimulating, and nurturing early relationships that ensure the emotional security and connection that advance physical health and development, social well-being, and resilience.

Most importantly, we asked for comments about the definition and received nearly 400, about 30% of which were positive comments with no suggested definitional changes. There were many others that suggested refining or further clarifying the wording: for example, specifying that early relational health refers to the 0-3 year old period, or that there is a bi-directionality to early relational health for both child and caregiver. There were also some critiques: “Why do we need a new term?”; “Isn’t this just Infant Mental Health?”; a worry about an over-emphasis on determinism; the vulnerability to dominant culture bias; or simply that it sounds too much like jargon. Yet, most striking was the general acceptability and comfort with the term and the draft definition.

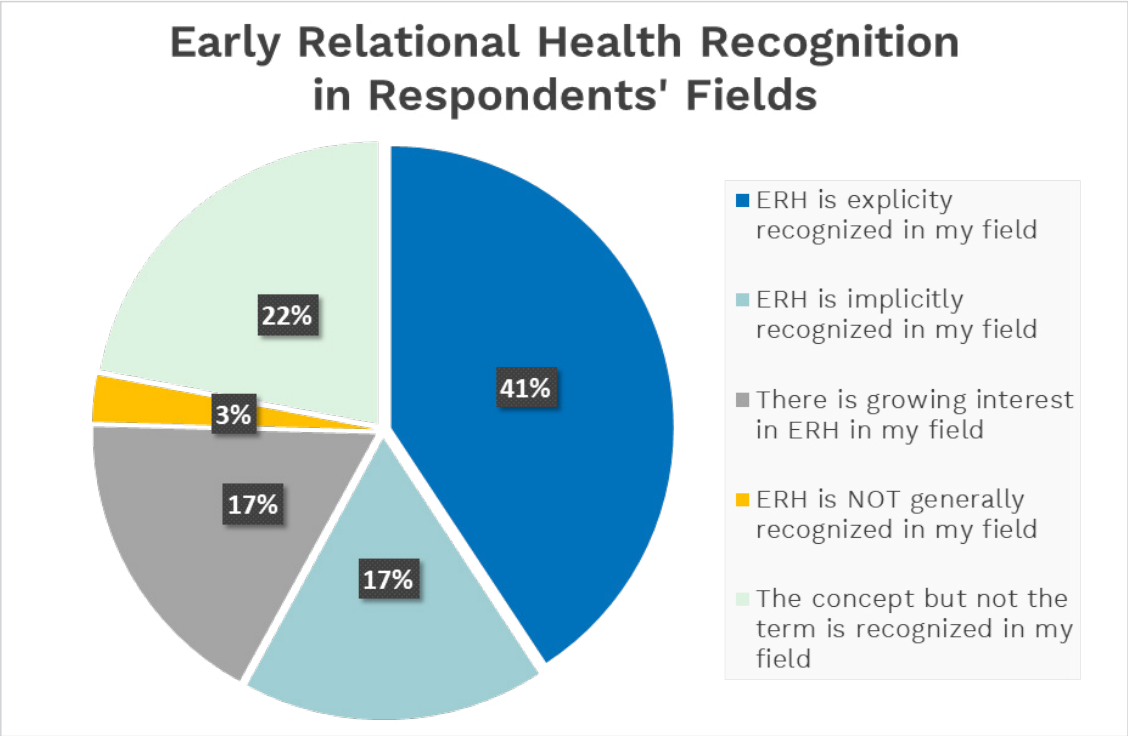
The respondents also understood the importance of early relational health to the healthy development of children and their life-long well-being. The survey supported our intuition that the concept is strong and understood as foundational.


How Important is Early Relational Health to Healthy Development?
Very important
Important
Somewhat
Not at all


How Important is Early Relational Health to Long Term Health?
Very Important
Important
Somewhat
Not at all

Early Relational Health is widely but not universally recognized across early childhood programs and services.

The survey asked respondents to answer a series of statements about how well early relational health is recognized in their field of work.



The survey asked for examples of how early relational health is currently recognized in their field of work and more than 176 respondents replied:

- Health care providers noted that pediatric training emphasizes that physicians discuss positive parenting; the promotion of talk, read, and sing with their children; the discussion with parents of their experiences with their children; and the intentional observation of the well-being of the parent-child relationship.

- Health care providers also commented on the use of various screening tools to identify risks and vulnerabilities in relationships, like maternal depression screening, adverse childhood experiences (ACEs) screening and developmental screening.

- Pediatricians noted that Reach Out and Read is recently emphasizing early relational health as a broadening emphasis for their positive parenting and literacy promotion model.

- Home visitors were explicit that their work focused on strengthening the parent-child relationship in every home visit, often commenting on the use of reflective strategies to improve this relationship or highlight the caregiver's response/ interaction. They also commented about the use of standardized parent-child interaction tools as a part of their daily work.

- Public health respondents noted their training efforts on trauma, ACEs, and the importance of relational buffers. Public health respondents also frequently cited the importance of home visiting as a relational approach.

- Family support workers noted their training on strengthening parent-child relationships and the use of Circle of Security-Parenting and Conscious Discipline curriculums.

- Early care and education providers mentioned their growing focus on social-emotional learning, the teacher-child relationship, and peer-to-peer social teaching. They also reported that some have adopted a relationship coaching model for teacher training focused on reflective practice and strengthening the teacher relationship with children. Others mentioned training and curriculum that emphasizes the critical importance of foundational relationships to child well-being; e.g. trauma-informed care, Nurturing Parenting, DIR (Developmental, Individual Difference and Relationship-Based) training, Pyramid framework, and home visiting training on social-emotional development. Others noted recent state and local initiatives that focused on early childhood mental health and infant well-being, with a strong early relational focus.

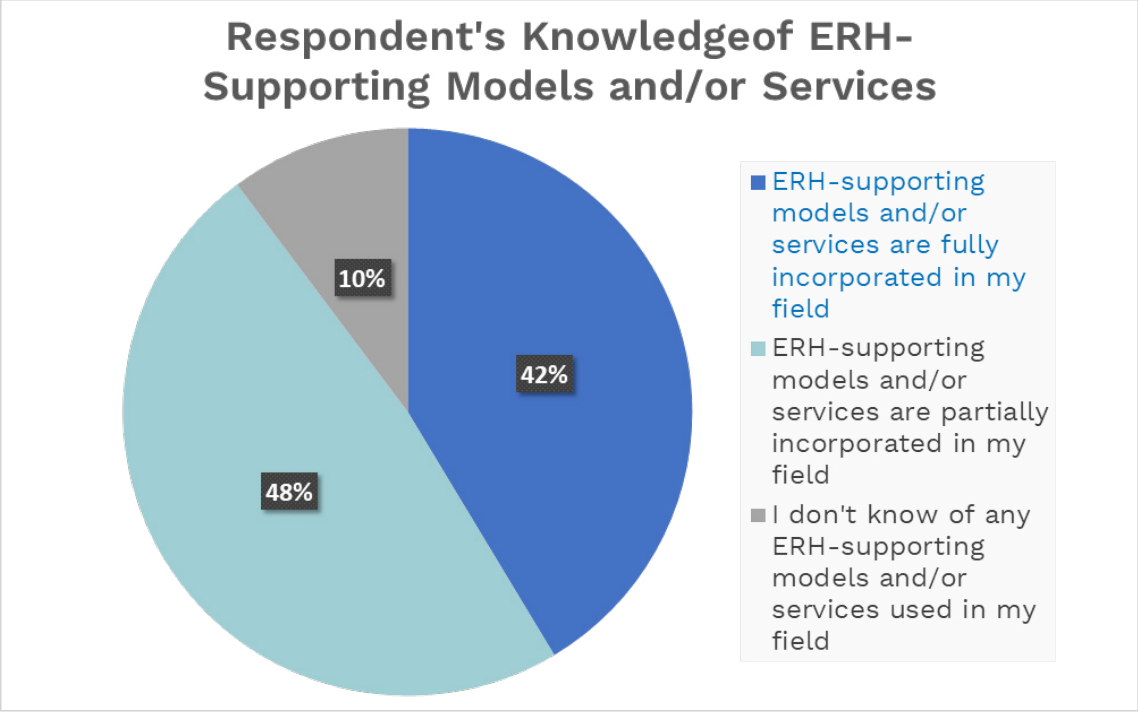
The survey participants were also asked to discuss what would be different if their field more fully realized the importance of foundational relationships. The responses were clear, consistent, and like themes are noted below. The respondents identified that expanded services and supports for young families and their relationships would make a dramatic difference in the lives of families and communities, and they were in strong support of policies that would achieve those goals.

Most frequently noted policy/ practice change if your field more fully recognized the importance of healthy early relationships:

- Universal continuum of home visiting
- Universal paid family leave
- Expanded parent education
- Expanded promotion, prevention, and early interventions for families
- Transformation of child health care
- Expanded training across all workforce

Early relational health-supporting models and services are already incorporated across the early childhood field.

The survey asked respondents to answer a series of statements about their knowledge of ERH-supporting models and/ or services within their fields.



ERH-SUPPORTING MODELS AND/OR SERVICES CITED BY RESPONDENTS

Home visiting
- Healthy Families America
- Nurse Family Partnership (NFP)
- Parents as Teachers
- Family Connects
- Dance in NFP, CHEERS in HFA
- Child First
- FAN Training

Parent education
- Circle of Security-Parenting
- NCAST
- Strengthening Families Framework
- VROOM
- Talking is teaching
- Play and Learning Strategies (PAL)
- Incredible Years
- Growing Great Kids Curriculum
- Lemonade for Life
- Read/talk/sing

Programs
- MOM Power
- Nurturing Parenting
- Triple P

Early Care and Education /QRIS
- Pyramid Plus approach
- Head Start/ Early Head Start
- FIND (Filming Interactions to Nurture Development)
- Touchpoints
- DIR (Developmental, Individual Difference and Relationship-Based) Training

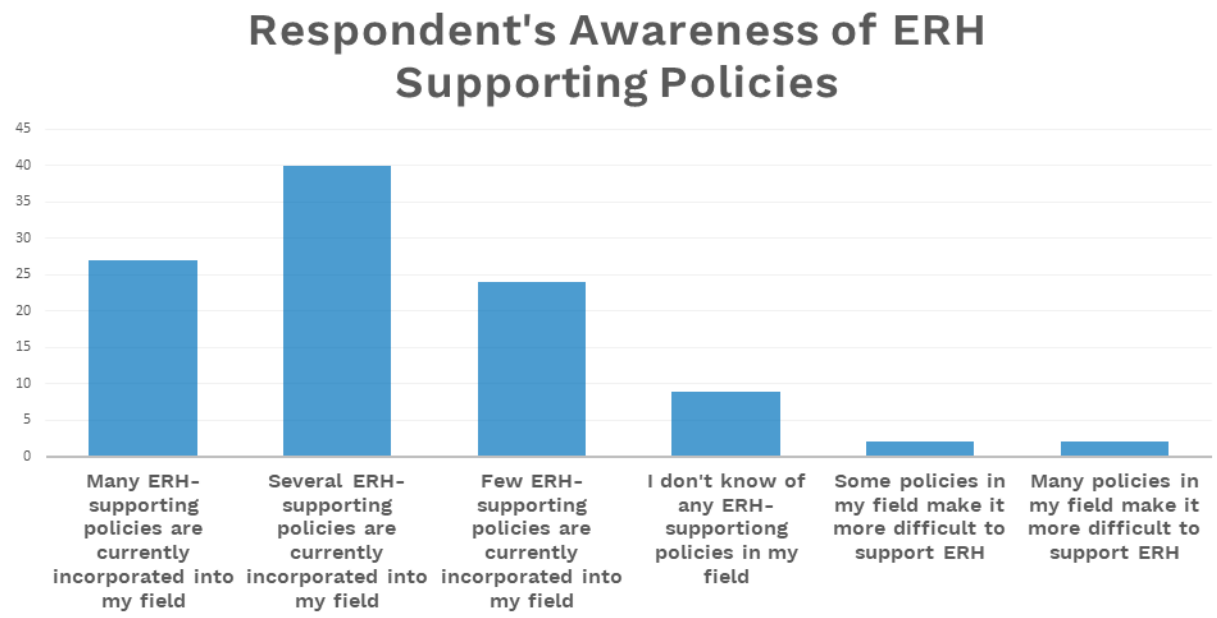
Advanced medical home
- Reach Out and Read
- Promoting First Relationships (PFR)
- DULCE, HealthySteps
- FIND (Filming Interactions to Nurture Development)
- Video Interaction Project (VIP
- FAN (Facilitating Attuned Training Interactions)
- Early Relational Health Screening and video feedback

What stands out is the breadth of evidence-based and well-developed models and services that already exist and can support early relational health practices across the nation, yet none of which are fully scaled nor saturated in communities for population health impact.

There is broad recognition of the need for policy and financing strategies to both promote and sustain ERH-related practice.

We were very interested the field's awareness of policy and financing strategies that support early relational health related practices. The survey asked:

> **As background, some states, communities, and programs have advanced policies that are ERH-supporting. For example, two-gen policies, paid family leave, universal home visiting, IECMH (Infant early childhood Mental health training), and consultation policies, IMH (Infant mental health) reflective practice requirements, ACE (adverse childhood experience), maternal depression, SDOH (social determinants of health) required screenings, etc. To what extent are ERH-supporting policies incorporated in your field of work?**



More than 400 people responded to the question about describing one or two ERH-related supporting policies. Strikingly, most of the respondents noted specific programs or practices (e.g. home visiting, Healthy Steps, Reach Out and Read), rather than policies. Also, some of the responses were more about program requirements and new initiatives that supported ERH-related activities, with only a few focusing on policy. The responses fell into three main categories: screening initiatives, program requirements, and supportive state policies, as summarized below.

Policies that Promote Early Relational Health

Screening initiatives
- Maternal depression screening and referral
- ASQ: Developmental and Social-emotional screening
- Required ACEs screening, training, and referral

Program Requirements
- Reflective supervision and practices
- Required IMH endorsements or certifications for consultants
- Required parent-child relationship assessments e.g., HV (CHEERS, DANCE, Piccolo)
- Infant mental health consultation

State policies
- Paid family leave
- Universal home visiting
- Reflective supervision for all state home visiting programs
- Flexible workplace schedules for parents
- Funded Safe Baby Courts
- Access to infant mental health consultation in all counties

Policies that create impediments to supporting early relational health.

We also asked the respondents to describe one or two existing policies that make it difficult to support early relational health in their field of work. We received 352 answers across a range of issues from policy to practice barriers which were best captured in three major themes: policy barriers, practice barriers, financing barriers.

- **Policy barriers:** limited access to paid family leave; no national child health or family policy; limited health insurance support for dyadic interventions; disparities in access to quality of childcare; limited mental health and infant mental health access and supportive policies; and budget cuts to services.

- **Practice barriers:** overemphasis on maintaining caseloads; lack of dedicated time for early relational health activities; limited infant mental health practitioners; limited referral resources; no administrative support for early relational health activities; and limited professional training and ongoing support for building staff capacities and workforce.

- **Financing barriers:** insufficient funding for Infant Mental Health (IMH) and Infant Early Childhood Mental Health consultation (IECMHC); inadequate reimbursement rates; underfunded scaling for home visiting and Early Head Start; unaffordable training; over-focus on billable services; limited financial support for innovative interventions; and insurance coverage barriers for children and families.

Recommendations for best practices, program models, or policies to further promote early relational health.

We were very interested in the fields' recommendations to further early relational health practices and policies. More than 400 respondents provided answers that clustered into the categories as noted below:

Best Practices, Program Models, or Policies to Further Promote Early Relational Health

Universal Family-Supportive Policies

- Expanded paid family leave
- Quality childcare
- Living wage for families/ECE workforce
- Universal basic income
- Universal healthcare
- Substance abuse treatment programs
- Mental health programs

Home Visiting

- Universal home visiting, including prenatal
- Expanded EB home visiting: HFA, PAT, NFP, etc.
- IMH-HV Models
- Reflective Supervision in all HV models

Measurement/Screening

- Early relational health screening, video feedback
- ACE's screening Trauma screening
- Mental Health screening
- ASQ
- Newborn Behavioral Assessment
- Parent-Child Early Relationship assessment

Best Practices, Program Models, or Policies to Further Promote Early Relational Health (Continued)

Exemplary Programs/Initiatives

- Simple Interactions
- Filming Interactions to Nurture Development (FIND)
- Promoting First Relationships (PFR)
- Child Parent Psychotherapy CPP
- Centering pregnancy/parenting
- Incredible Years curriculum
- Mom Power
- Circle of Security-Parenting
- IECMHC
- Family Connects
- VROOM
- Strengthening Families

Cautions, concerns, and hesitancies in the advancement of early relational health.

We have been mindful from the start of the importance of family voice, attention to parent and cultural perspectives, and the risks of judgement and bias by service and system providers as early relational health progresses across the health and early childhood systems. Near the conclusion of the survey, we posed the following question seeking responses and reflections on this issue in narrative form:

In conversations with some of our parent leaders in the Black and Native American communities, they want to make sure that this new term/ approach is not another way to judge them or remove their children from their care. What other concerns, hesitancies, or cautions come to mind for us to consider?

Here are some of the comments, from more than 400 responses representing the wisdom and experience of professionals attempting to work with respect, cultural humility, and authentic partnership with parents, and yearning for greater efforts to support the parent-child relational health:

Stigma, judgement, and bias

"Adding more shame/ blame to parents, particularly mothers working outside the home."

"Stigmas around parent mental health."

"Labeling parents as bad when ERH is low."

"Ensuring that there is truly a shared power/ parents as experts in their lives approach, acknowledging [that] positive exists in all communities and can be nurtured."

Cultural competence and the voice of parents

"ERH must include the voices of a diverse group of parents in leadership and avoid a 'telling how' approach."

"[Must] be mindful of culture, values, and traditions."

"Let's make sure we are teaching ERH that is culturally competent—it seems there is no 'one size fits all' ERH and the programming has to be uniform so that there is consistency in application and outcomes, but customized enough to reflect the needs and traumas of different communities, particularly Black, Hispanic, and Native American communities."

"Cultural competency and trauma-informed work is critical... public health education, outreach, and curriculum delivery must be rendered from a diversity, equity, and inclusion lens."

"Recognize that different ethnic/racial/cultural groups may approach and build early relationships in diverse ways that appear different from typical Western models of parenting/ caregiving."

"Just making sure that parent leaders and parents in the community are included (in some way) in the conversation about developing curriculum and support THEY are needing (rather than what others assume they need)."

Clarity of communication

"It is important to emphasize the universality of the importance of early relational health. This is good for all families and caregivers."

"It will likely be a challenge to reach broad understanding of a term that feels very generic. So, the word 'relational' may mean different things to different people—could people think it means biology—relatives, family groupings, genetics, sex, getting along with others? Etc."

"I think you need to explain this is just a new framing of something we all already understand is valuable and ideally positions us to secure more support from others—funders, elected officials, policymakers, etc., to ensure families are supported to develop it."

"Any messaging should also focus on what to do if you missed the early years, so caregivers don't think it's too late to support their child."

"Just another buzz term."

"'Relational' isn't a word that's used in mainstream conversation, but it is a word used in the early childhood field. If you want this to become common language everywhere, I think you will need to find a much simpler definition than what's presented above with everyday language."

"The term 'Early Relationship Health' sounds very 'hippie,' 'White,' 'upper class' and 'new agey.' As a Caucasian professional woman and a pediatrician, I find it off putting."

Field challenges

"Trying to take a top down approach to something we should be strengthening from the bottom up."

"This is a 180 [degrees] different from the medical model which is the system that has the most likelihood of reaching all children under 3. When the Wisconsin Birth to 3 Program started emphasizing the Primary Coach approach, I believe it caused us to lose some credibility with the medical community."

"Field is historically dominated by White women. Need more people of color driving policy and leadership"

"Ensuring that there is truly a shared power/ parents as experts in their lives approach, acknowledging positive exists in all communities that needs to, and can be, nurtured."

"Must be strengths-based and include efforts to reduce implicit bias."

Advancing early relational health.

Finally, we were interested in ideas of how to advance early relational health, to encourage others in their fields to adopt an ERH perspective and how respondents would rank the value of a series of field building activities. 563 respondents ranked the following prompts: (% ranking 1st or 2nd).

Respondents' ranking of field-building activities

53% Policy development for advancing ERH practices: Briefing materials, guidance, and monitoring state/community processes

45% Framing toolkit, including branding and messaging resources—a series of in-depth guides to advance ERH, messaging, and dissemination strategies

42% Training webinars: ongoing series of training and implementation webinars activities using data driven CQI principles and efforts

36% CQI initiatives for advancing practice change: practical practice-based adoption of a new ERH activity

24% Virtual working groups: as collaborative learning labs

7% Others

Unexpectedly, the survey captured the interest of 348 individuals who provided their emails and indicated interest in joining monthly calls over a 12-month period for a virtual Early Relational Health Action Learning Lab.

This finding alone, indicates the fields' eagerness for further learning, training, and discovery across all the fields participating in the survey.

WHAT WE HAVE LEARNED

The early relational health survey captured the interest and attention of a broad cohort of early childhood providers across over 11 related early childhood fields, 16 identified networks, and most major early childhood disciplines (child health, mental health, public health, social support, early education, childcare, and policy). We believe this has given us a robust view of current ERH-related activities, best practices, policy needs, and interests as experienced in communities, programs, and services across the nation's early childhood sectors and systems. Respondents shared their collective wisdom about their interest and what would be needed to further advance an early relational health agenda. The following capture these key learnings:

- There is a strong, broad, and building interest in early relational health. The 584 respondents were knowledgeable of the concept and in support of a draft definition. Their reflections demonstrated their an awareness of needthe importance of an early relational focus, current activities in that are in support of relationships and the policy, training and practice needs. That over more than half of the respondents are interested in a future monthly virtual ERH learning action lab also provides evidence of a building growing national interest.

- Many early childhood stakeholders are eager to identify how to translate early relational health concepts into clear, actionable policy and practice change. There are a wide range of known current early relational health models and practices, but respondents identified the need to strategies to scale these efforts and to focus on policy and financing supports.

- Reflective supervision and ongoing training and support will be required for a future competent ERH workforce, regardless of discipline. Future training must also include the development of authentic partnerships with parents to address cultural and development biases that are often a part of current child health and early childhood service systems.
- There is broad recognition of the need for policy and financing strategies to both promote and sustain ERH-related practices. Half of

the respondents saw the need for policy development given significant structural barriers. They Respondents were most eager for materials, guidance, and monitoring of policy opportunities and activities that would advance early relational health.

- The term, “early relational health” must be carefully defined with special attention to the framing of all communications. Early relational health is a term, not a new field , yet was understood to call out the universal need to focus on foundational relationships. The field is eager for further framing, messaging, and dissemination strategies that can be adopted across networks, fields, and communities.

- Advancing early relational health must place families and family leadership in the lead. Partnering with families and honoring the resiliency, strengths, and history of all families and communities is foundational to any transformational effort to advance early relational health in early childhood systems, especially the health sector.

- Advancing early relational health must also be done within an anti-racist framework. To advance early relational health will require all service systems to be reflective, transparent, and anti-racist, in order to address the many barriers to the supports and needs for young children and families of color and various immigration status. Advancing ERH will require directly addressing the structural and institutional racism in our society.

NEXT STEPS

- **Establish an Early Relational Health Coordination Hub.** Given the high degree of interest, the survey points to the need for an organized, efficient, and coordinated effort to advance an early relational health agenda. A coordinating hub that advances communication, learnings, innovative activities, network leadership, and dissemination of discovery is central to this transformational agenda. This hub would, among other things, organize a monthly virtual Early Relational Health Learning Lab and begin to disseminate communication, messaging, and framing materials, from a central point for communication and dissemination.

- **Create early relational framework communication and messaging strategies.** The survey identified the need for further messaging and framing materials. The next phase of work will be to partner with families and communities to further develop and test the communication of the concepts, principles, and practices associated with early relational health for the fields of pediatrics and child health, public health, community-based early childhood systems, and with parents and caregivers.

- **Partner with National Networks for Practice Change.** The survey included the perspectives of more than 11 different early childhood networks and elevated the many opportunities to strategically engage with those networks to promote an early relational health agenda.

- **Develop an Early Relational Health Policy Agenda.** A policy agenda with strong attention to sustainable financing strategies to support and scale practice, program, and system innovations is an essential next step. This includes identifying policy and financing opportunities at the state and local level as well as a longer-term focus on a federal policy agenda.

REFERENCES

[1] FrameWorks Institute, "Building Relationships: Framing Early Relational Health," Washington, DC, March 2020.

APPENDIX A: EARLY RELATIONAL HEALTH SURVEY

Survey Questions:

Q1. What is your contact information? (optional)

Q2. If applicable, which network(s) are you from?
- EC-LINC
- EC-COIN
- Help Me Grow
- NCIT
- StriveTogether
- Strengthening Families
- Reach Out and Read
- BUILD
- ZERO TO THREE
- HealthySteps
- Home Visiting
- Early Learning Nation
- AAIMH
- IECMH
- Early Childhood
- Other

Q3. Which of the following best describes your field of work?
- Healthcare
- Public health
- Early learning/early care and education
- Education (K-12)
- Family support
- Home visiting
- Child Welfare
- Early childhood community systems
- Public policy
- Advocacy
- National Early Relational Health Advisory Team member
- Other (specify)_____

Q4. Where is your office/work located?
City/County:_____ State:_____

Q5. Which of the following best describes your organization/agency?
- Public sector – City/county agency
- Public sector – State agency
- Public sector – Federal agency

- Non-profit – City/county focus
- Non-profit – State focus
- Non-profit – National
- For-profit – Specify focus _____
- Private Clinics
- Public Clinics
- I am a volunteer or private consultant

Q6. How knowledgeable do you feel you are about the concept of Early Relational Health? (1= not at all 5= very)

Q7. How well does the following working definition fit your understanding of ERH? (1 not at all; 5 fits well):

> **"Early relational health describes the positive, stimulating, and nurturing early relationships that ensure the emotional security and connection that advance physical health and development, social well-being, and resilience."**

Q8. What would you add (or subtract) from this definition? What would you change to improve it?

Q9. How important do you think ERH is to healthy development in young children? (1=not important; 5 very important)

Q10. How important do you think ERH is to life-long well-being? (1=not impt; 5=very impt)

Q11. To what extent is ERH recognized in your field of work? (check all that apply)
- ERH is explicitly recognized in my field of work as critical to healthy development.
- ERH is implicitly recognized in my field of work as critical to healthy development.
- There is growing interest in ERH in my field of work.
- ERH is not generally recognized or incorporated into my field of work.
- The concept but not the term is recognized in my field of work.
- If applicable, please describe an example of how ERH is recognized in your work/field of work:_____

Q12. Can you identify how your work might change if your field of work more fully realized the importance of healthy early relationships?
Please describe: _____

Q13. TOOLS/MODELS: As background, many practices, agencies or communities already have some models or strategies in place that help promote strong parent-child relationships and build the foundations of ERH. Some examples include, Reach Out and Read, Promoting First Relationships, Circle of Security, home visiting, CHEER or DANCE within home visiting, Simple Interactions for ECE, Vroom, Triple P, DULCE, Healthy Steps, Centering pregnancy/parenting, etc.

To what extent are ERH-supporting models and/or services incorporated in your field of work? (check all that apply)
- ERH-supporting models and/or services are fully incorporated into my field of work.
- ERH-supporting models and/or services are partially incorporated into my field of work.
- I don't know of any ERH-supporting models and/or services used in my field of work.
- If applicable, please describe 1 or 2 ERH-supporting models and/or services used in your field of work.

Q14. POLICIES: As background, some states, communities and programs have advanced

policies that are ERH-supporting. For example, two-gen policies, paid family leave, universal home visiting, IECMH (Infant early childhood Mental health training) and consultation policies, IMH (Infant mental health) reflective practice requirements, ACE (adverse childhood experience), maternal depression, SDOH (social determinants of health) required screenings, etc.

To what extent are ERH-supporting policies incorporated in your field of work?

- Many ERH-supporting policies are currently incorporated into my field of work.
- Several ERH-supporting policies are currently incorporated into my field of work.
- Few ERH-supporting policies are currently incorporated into my field of work.
- I don't know of any ERH-supporting policies incorporated into my field of work.
- Some policies in my field of work make it more difficult to support ERH.
- Many policies in my field of work make it more difficult to support ERH.

Q15. If applicable, please describe 1 or 2 ERH-related supporting policies in your field of work: _____

Q16. If applicable, please describe 1 or 2 policies that make it difficult to support ERH in your field of work: _____

Q17. What are 1 or 2 best practices, program models, or policies you would recommend to further promote ERH? Please specify: _____

Q18. If you were going to champion the importance of ERH and of adopting an ERH perspective to members of your field, how would you rank the value of some of the following activities to advance ERH? (Rank from 1-5, 1 being most important)

- Training webinars – ongoing series of training and implementation webinars
- CQI initiatives for advancing practice change – practical practice-base adoption of a new ERH activities using data driven QI principles and efforts
- Framing toolkit, including branding and messaging resources – a series of in-depth guides to advancing ERH, messaging and dissemination strategies
- Virtual working groups– as collaborative learning labs
- Policy development for advancing ERH practices – briefing materials, guidance and monitoring state/community processes
- Others

Q19. What is the most important barrier to adopting/integrating an ERH perspective in your field of work? (Describe)

Q20. In conversations with some of our parent leaders in the Black and Native American communities, they want to make sure that this new term/approach is not another way to judge them or remove their children from their care. What other concerns, hesitancies or cautions come to mind for us to consider? _____

Q21. CSSP is planning a virtual ERH Action Learning Lab with representatives from local (city/county) early childhood systems across the country. If you are interested in potentially joining this group for monthly calls over a 12-month period, please provide your contact information below:

Name:_____
Title and Organization: _____
Email address:_____

Q22. Any additional comments? _____

Thank you!