Using Mental Health Strategies to Move the Early Childhood Agenda and Promote School Readiness

Starting Points

Meeting the Needs of Our Youngest Children

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Using Mental Health Strategies to Move the Early Childhood Agenda and Promote School Readiness

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OVERVIEW

This issue brief highlights emerging strategies to promote the emotional wellness of young children and their families, including those most at risk; to enhance the skills of the families and other caregivers who nurture and support young children; and to ensure that those who need specialized services get them.

It describes a number of initiatives developed across the nation, with an emphasis on two Starting Points sites, San Francisco and Vermont.

Key strategies discussed include:

- Developing mental health consultation for child care and early learning programs.
- Enhancing mental health support to home visiting programs.
- Promoting healthy relationships in the context of early health care.
- Promoting emotional wellness of young children and their families through a statewide approach.

Introduction[1]

A growing body of research shows that promoting the emotional wellness of young children and fostering secure, warm relationships with parents and other caregivers are keys to healthy early development and later school success.[2] These early experiences set the stage for how children relate to other children, how they relate to adults, how they manage anger, and how they feel about themselves. They also set the stage for how well they will do in school.

MENTAL HEALTH AND SCHOOL READINESS

For many children, early emotional development proceeds smoothly, and they develop the kinds of behavioral skills that will help ensure that they enter school ready to succeed. But a significant number of young children are showing early signs of emotional distress and behavioral problems. Recent research indicates

In 1994, the publication of *Starting Points: Meeting the Needs of Our Youngest Children* by Carnegie Corporation of New York heralded a "quiet crisis" for our nation's youngest children. Today, the crisis is no longer quite so quiet. The 11 states and cities that are part of the Starting Points State and Community Partnerships are part of a growing chorus focused on improving the lives of young children and their families. This brief is one of a set of products sharing the experiences of Starting Points sites, as well as other states and localities, to help the nation move towards a healthy, nurturing beginning for all its children.

Emotional Development, Relationships, and School Readiness: Research and the Case for Early Childhood Mental Health Strategies[3]

- Estimates are that between one-quarter and one-third of young children are perceived as not being ready to succeed in school. For a significant number of these children, concerns center around emotional development.
- Early brain research tells us that not only do early experiences relate to later cognitive development, but they seem to be especially related to children's emotional development and their ability to manage emotions and behaviors. This, in turn, is related to school readiness.
- Children for whom early relationships have been inconsistent or harsh or who have been exposed to violence are particularly vulnerable to compromised emotional development and poor school performance.
- Practice wisdom, although not yet rigorous evaluation, suggests that more intensive family- and child-focused interventions explicitly designed to repair damaged relationships can help young children exposed to multiple risk factors.
- Nurturing, caring, and stimulating early childhood programs that include both family support and developmentally appropriate practices can help mitigate risks to development and promote school readiness.
- Early care and education experiences are often of poor quality, especially for infants and toddlers, yet this is just when the importance of nurturing, language-enriched relationships are so vital.

For all these evidence-based reasons, strategies that promote emotional health in young children in the context of early family and other caregiving experiences are assuming a new urgency.

that pediatricians are prescribing psychotropic drugs for very young children with behavioral problems.[4] Staff in a wide range of programs—Head Start, Early Head Start, child care, and home visiting programs—report great concern about these children, and often, their families. They say that their usual approaches often do not work, but they do not know where to turn for help. Many communities report that young children are being excluded from child care settings because of their behaviors. Other research suggests that early emotional and behavioral problems are either ignored or misidentified.[5] None of this bodes well for these children entering school and succeeding. This issue brief highlights some of the strategies that programs, communities, and states are developing to challenge the odds.

A FRAMEWORK FOR INTERVENTIONS

Young children whose emotional and behavioral development is of concern are a heterogeneous group. They are children in families where poverty has taken a great toll on parents or other relative caregivers, leaving them with little energy or skills to nurture and stimulate their children. They are children struggling

What Prevention, Early Intervention, and Intensive Early Childhood Mental Health Strategies Should Do[6]

- Enhance the emotional and behavioral well-being of young children, particularly those whose emotional development is compromised by virtue of poverty or other environmental or biological risk factors;
- Help families of young children address the barriers they face to ensure that, as children's first nurturers and teachers, parents promote their children's healthy emotional development;
- Expand the competencies of non-familial caregivers (e.g., child care providers, home visitors, Early Head Start and Head Start staff, health care providers) to promote the emotional well-being of young children and families; and
- Ensure that young children experiencing clearly atypical emotional and behavioral development and their families have access to needed services and supports.

to negotiate transitions among multiple caregivers. Some are young children who show the scars stemming from serious family problems, such as depression, substance abuse, domestic discord, or violence. And still others—a smaller group—are children showing early signs of serious emotional difficulties that reach diagnosable levels.

This heterogeneity means that promoting emotional wellness* in early childhood must encompass a range of strategies that are sufficiently flexible and robust to help such families, staff, and even communities to address prevention and early intervention as well as more intensive needs.

Implicit in this framework is a very important idea: Often, the best way to help young children is to change the way that parents, caregivers, and others relate to them. Of course, working directly with the children can also be important. Research also suggests that neighborhoods and communities affect children's development, and that unsafe and unhealthy ones can cause harm.[7] This, too, is influencing the shape of emerging initiatives, sometimes resulting in a focus not just on children, staff, and families, but on community-building efforts as well.

1. Strategies to Promote Emotional Wellness

This section identifies early childhood mental health strategies that can be implemented where the children and families are found—in early care and education settings, health care offices and clinics, and their own homes. Some of the strategies emphasize prevention, others early intervention. Some focus more on helping staff help children, others more on helping staff help families. Most incorporate attention to both child and family relationships, as well as staff-to-staff and staff-to-child relationships. A few incorporate a community focus. All can be used by other programs and communities to strengthen their own responses to promoting emotional wellness in young children.

* Note: The terms "early childhood mental health" and "the promotion of emotional wellness" are used interchangeably in this issue brief. Emotional wellness is a more acceptable and easily understood term to a broad group of stakeholders. But mental health systems, skills, and funds are often involved in developing strategies to promote emotional wellness, even for high-risk children and families.

What Early Childhood Mental Health Consultants Do in Early Care and Learning Settings

Mental health consultants carry out a range of tasks to enhance the emotional and behavioral well-being of children, families and staff. For example, they:

- Help early childhood staff observe and understand behavior.
- Team with early childhood staff to design classroom interventions to promote emotional strengths and strong relationships, including social skill building.
- Provide information about what to expect in infants, toddlers, and preschoolers, and the importance of early relationships for them.
- Increase staff competencies in dealing with children with challenging behaviors or problematic emotional development.
- Help staff work more effectively with families, individually or through parent support groups.
- Help staff know when children or families need more specialized help.
- Help staff address cultural or other work-place tensions.
- Help children, staff, programs, and communities respond to community or family violence or other crises.

STRATEGY 1: DEVELOP MENTAL HEALTH CONSULTATION TO CHILD CARE AND EARLY LEARNING PROGRAMS.

One major strategy to enhance the emotional and behavioral development of young children is to connect early childhood programs with mental health consultants. Early childhood mental health consultation brings mental health expertise to where the children and families are in the same way that school-based mental health services bring mental health expertise to where older children are. The specifics of the interventions and developmental issues addressed vary, but the core principles are similar. Research and experience suggest that for an early childhood mental health consultation strategy to be effective, the consultants must win the trust of the staff, be knowledgeable about child and family development behavioral issues, and understand how to help staff work directly with young children and families.[8] Consultants can be connected to individual programs, or, on a community-wide basis, to a network of programs. Where such communitywide efforts are being implemented, system development issues such as recruiting consultants with the needed competencies, creating training and orientation for the consultants, designing quality assurance mechanisms and practice standards, and ensuring ongoing funding are also emerging.

✦ The High Quality Child Care Mental Health Consultation Program, San Francisco, California

Recognizing the importance of promoting sound emotional development in young children, San Francisco has developed the High Quality Child Care Mental Health Consultation Program through a partnership that includes the San Francisco Starting Points Early Childhood Interagency Council (ECIC), the child care community, and two county agencies. (The county agencies are the Children, Youth, and Family Section of the Department of Public Health-Community Mental Health Services, which administers the initiative, and the Mayor's Department of Children, Youth, and Their Families in the San Francisco Department of Human Services.) To pay for the initiative, the San Francisco Board of Supervisors allocated $730,000 as part of a citywide child care quality improvement fund that, in turn, was used to leverage an additional $1.2 million drawn from CALWorks (TANF) monies.

As part of its overall mission to enhance the school readiness of San Francisco's young children, the ECIC, made up of a broad group of service providers, policymakers, and community leaders, convened a Mental Health Work Group. This group laid the groundwork for a citywide community-based mental health consultation initiative that began in April 1999. Through the initiative, funds are provided to eight community agencies: Children's Council of San Francisco, Family Service Agency of San Francisco, Fu Yau Project (Richmond Area Multi-Services/Chinatown Child Development Center), Homeless Children's Network, Instituto Familiar de la Raza, San Francisco Psychoanalytic Institute, Parents Place-Jewish Family and Children's Services/Day Care Consultants, and Westside Community Mental Health Center. Each grantee works with its own network of local child care centers and family child care providers. Together the initiative provides early childhood mental health consultation to 75 center-based programs and 90 family child care providers serving low-income infants and toddlers, prekindergarten, and special needs children. The organizations providing the multi-lingual and multi-cultural services to the child care settings are reimbursed for five categories of early childhood mental health activities: (1) program and case consultation (including child or classroom observations) directed to either individuals or groups; (2) staff provider training or parent support activities; (3) direct service to the child and family through individual or family therapy or therapeutic groups with children; (4) administrative services, and (5) evaluation.

Preliminary findings from a cross-site evaluation suggest that the consultation is reaching the intended group of children—those receiving the services show a developmental delay in social maturity that averages almost two years. The mental health initiative has grown out of a long-standing recognition of the importance of early childhood mental health consultation in San Francisco. In 1988, the Day Care Consultant Program of the Infant-Parent Mental Health Services Program at San Francisco General Hospital was started. This was followed, in 1991, by a Quality Child Care Mental Health Collaborative (QCCMHC) initiative, supported by the Children's Fund. (The Children's Fund comes from the percentage of the property tax that is dedicated to children's services. These funds are distributed by the Mayor's Department of Children, Youth, and Their Families.) Between 1995 and 1999, the Miriam and Peter Haas Fund provided additional funds for mental health consultation through the Early Childhood Collaborative Training and Services Project. All this has helped set the stage for the current effort. The Mental Health Work Group of the ECIC is now developing a set of practice standards that can be used to enhance comparability across the sites and describe the components of early childhood mental health consultation in a way that will be useful to funders, providers, and policymakers.

✦ Day Care Plus, Cuyahoga County, Ohio

In Cuyahoga County, Ohio, the Early Intervention Centers of the Positive Education Program, a highly respected, parent-driven early intervention program for the most challenged and challenging children and their families, has joined forces with the local child care resource and referral agency to develop a consultation and outreach program for local child care centers. Started three years ago as a partnership among the Positive Education Program's Early Intervention Centers, the local child care resource and referral agency, and the county mental health board, the initiative has grown rapidly and is now funded as part of

Cuyahoga County's larger Early Childhood Initiative. Day Care Plus was initially and continues to be conceptualized as a child care quality improvement strategy that uses mental health consultation. The explicit aims are to maintain young children with challenging behaviors in their existing child care settings, increase the competencies of child care staff (in order to improve the quality of the program, reduce staff stress, and ultimately staff turnover), and help parents of at-risk children who are in child care settings to be more effective.

When Day Care Plus started, it targeted ten centers, using a train-the-trainer model, as well as ten control centers. The program is now working with 31 centers (including the ten control centers) and has recently expanded to a staff of six full-time consultants. In addition to the center-based consultation, this year Day Care Plus has added a Community Response Team of two full-time consultants who go into centers and certified family child care homes to provide crisis intervention and consultation. All Day Care Plus consultants receive training at the Early Intervention Centers. (The Early Intervention Centers' programs are structured so that parents of behaviorally-challenged children become coaches for other parents in addition to having access to very strong individual and peer support.) It is estimated that 40 percent of the Day Care Plus consultants' time is spent working directly with staff and 60 percent with individual children and/or families. The response of the early childhood community has been very positive; requests to participate are significantly more than can be handled. Early indications are that the "response team" strategy will also be very important in helping the early childhood community.

Funding for Day Care Plus initially involved support from United Way and several local community foundations as well as county mental health dollars. Now, the effort is funded primarily with public dollars through the Cuyahoga County Early Childhood Initiative and has reached over three-quarters of a million dollars. Initially, the foundation funds provided legitimacy as well as flexible dollars that were used to promote networking and information sharing among child care staff and staff from a variety of community agencies including substance abuse and mental health.

✦ Starting Early Starting Smart

Variations on a theme are also possible. In 1997, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) joined with a private group, the Casey Family Program, to create Starting Early Starting Smart (SESS), a public-private initiative. Together, with supplemental support from other federal agencies, they funded 11 grantees as part of a research and demonstration initiative to develop child-centered, family-focused, and community-based interventions in child care and child health settings. The aim was to support the healthy development of children up to age seven who are affected by alcohol or other substance abuse and serious mental health issues, and to prevent their entry or greater penetration into the child welfare system.

The SESS sites fall into three categories. Four programs are based in primary health care settings. Generally, these link low-income, high-risk families to specialists, provide basic advocacy services, help families develop concrete strategies to ensure the safety of their children, and, in some instances, offer special therapeutic interventions. Strategies at the six sites based in early childhood programs (five of them in Head Start settings) tend to be more child-focused, addressing the needs of children manifesting the most high-risk behaviors, although some include staff development activities and parent involvement strategies. The remaining program is designed to meet the needs of a Native American tribe. A national evaluation is currently under way. Informally those involved report being surprised at the number of children needing services and the positive impact the initiative is having on staff.

✦ Free to Grow Head Start Models, Columbia University

Free to Grow: Head Start Partnerships to Promote Substance-free Communities is an example of a broadly framed initiative that combines attention to child and family risk and protective factors with community-building strategies. Launched by the Robert Wood Johnson Foundation in 1994 in collaboration with the National Head Start Bureau, Free to Grow is designed to reduce the vulnerability of young children to substance abuse and other high-risk behaviors as they grow older. One of its core assumptions is that children's mental health requires not only healthy families, but healthy communities. Program models include strategies focused on strengthening families, such as incorporating intensive case management for high-risk families into the Head Start infrastructure or creating family-to-family mentoring networks. But the models also focus on community-strengthening activities, such as establishing neighborhood community action councils or "Safe Space Task Forces" that engage Head Start parents with other community residents and leaders in efforts to reduce the impact of alcohol, drug abuse, and related violence on their children.

STRATEGY 2: ENHANCE MENTAL HEALTH SUPPORT TO HOME VISITING PROGRAMS

For infants and toddlers, there is considerable interest in home visiting strategies as a way to promote healthy development. Just as staff in early care and learning programs report great concern about how to help the children and their families, so, too, do staff in home visiting programs. Of special concern are families affected by substance abuse, domestic violence, and mental illness—particularly depression—who have infants and toddlers. As with mental health strategies linked to early care and learning settings, there are many ways to strengthen the mental health focus in home visiting programs.[9]

✦ California Safe and Healthy Families (Cal-SAHF)

This home visiting program expects that the families it serves will have multiple and complex needs related to substance abuse, domestic violence, and mental health issues. Using the principles of psychosocial rehabilitation (which combine emotional support with concrete services to mentally ill adults), it aims to reduce the need for child welfare interventions, decrease psychiatric and other

medical costs, improve child health and developmental outcomes, promote positive parenting, and reduce dependence upon public assistance. Families receive individualized home visits supplemented by weekly groups for parents and children, help with child care and transportation, and other supports as needed. Multidisciplinary teams may include a licensed clinical social worker or registered nurse who acts as the team leader, home visitors, a child-development specialist, a group coordinator, a child care aid, and, increasingly, CALWorks/TANF staff. The teams work with 20-25 families at a time. The seven CALSAHF programs are being evaluated.[10] Program funding comes from a combination of federal (Child Abuse Prevention and Treatment Act) and state funds.

Vermont's Healthy Babies

Vermont's Healthy Babies home visiting program also recognizes that some families need different staffing patterns. It has forged an agreement allowing mental health professionals to become core providers if families being served by home visitors through Vermont's Healthy Babies program need more intensive services because of depression, substance abuse, domestic violence, or other complex needs. Known as family support workers with expertise in helping with mental health and related challenges, they work out of a broad range of settings, including rural health clinics, parent-child centers, and mental health centers.

Two other home visiting programs, Baltimore's Healthy Start and Project BEFORE in Kansas, have also developed mental health strategies. Although neither has been able to sustain their strategies, they are described here because they do suggest approaches that others might adapt, especially where cross-system collaboration is possible and agencies are creative about pooling funds.

Baltimore's Healthy Start

Baltimore's federally-funded Healthy Start home visiting program operates in a community where about 40 percent of the families have some involvement with substance abuse and many adults show signs of depression. Although all Healthy Start parents are high-risk, some are more high-risk than others. Motherly Love was developed to respond to the needs of the most high-risk parents and children. Specifically, Motherly Love was for families characterized by previous or current substance abuse, depression, severe problems in dealing with issues of daily life, or by the identification of potential developmental delays in their children. The overall objective of Motherly Love was to provide therapeutic interventions that would improve relationships between parents and their children and result in better parenting. The program, run by two highly-skilled infant mental health therapists, had three components: (1) an eight-week intervention, (2) an on-going follow-up support group, and (3) access to on-site counseling, evaluation, and referrals. The intervention involved two-hour weekly sessions that combined psychotherapy for the mothers, a therapeutic play group for the babies, and mother-baby interaction time. Both staff and families responded very positively to the program. Research confirms that integrated treatment strategies that combine attention to parental treatment needs, therapeutic and developmental interventions for the young children, and opportunities to observe and coach parents in the context of real interactions with their young children are key in working with such high-risk families.[11] Yet even so, Motherly Love was not sustainable because funding could not be pieced together.

Project BEFORE

Another example of a program seeking to provide integrated services to young children and their par-

ents that was not sustained comes from Project BEFORE (Bridging Empowers Families to Overcome Risks and Excel) in southeast Kansas. Project BEFORE was one of eight federal grants to existing substance abuse treatment or prevention and mental health programs to improve young children's current and future mental health and social development as well as general family functioning. It was targeted to young children (under age six) with parents who either had or were at risk of having a substance abuse or mental health problem. Training for the staff built on the Healthy Families America home visiting curriculum, supplemented by mental health/substance abuse skills and strategies. The service approach combined home visiting and case management with individualized supports to families, such as strengthening a family's informal support network or connecting a mother with a 12-step program. Each family designated key members of its case management team, which typically included the parent(s), the home visitor, an early childhood specialist, and one or two others (such as a supportive neighbor, or a mental health or vocational counselor). Many of the staff who worked directly with families were themselves in recovery, which proved to be a major asset.

A preliminary evaluation of the first 205 families served found improved utilization of both physical and behavioral health services for the mothers and their children, significant reduction in changeable risk factors (such as decreases in exposure to violence, substance use, child abuse, and family arrests) and increases in the numbers of women working or in treatment, even though this program preceded TANF and there were no explicit work-related goals. (At intake, 17 percent of the women were working or going to school; after six months, 67 percent were working and 19 percent were going to school.)[12]

STRATEGY 3: PROMOTE HEALTHY RELATIONSHIPS IN THE CONTEXT OF EARLY HEALTH CARE.

The mental health strategies highlighted above are being implemented primarily in the context of child care and early learning, or home visiting and sometimes, health or mental health settings. Most involve mental health and related professionals. The following two strategies do not typically involve mental health professionals, but they do provide powerful opportunities to use the same range of settings to engage in prevention activities designed to promote healthy parent-child relationships before problems surface.

✦ Reach Out and Read, Boston Medical Center, Boston, Massachusetts

Reach Out and Read is a pediatric intervention designed to help parents and children enjoy pre-reading experiences. The heart of the program involves anticipatory guidance for parents from pediatric clinicians about communicating and reading with young children in ways that bring pleasure to both. Program components also include giving each child a developmentally and culturally appropriate book at each pediatric visit and having volunteers model developmentally appropriate reading to the parents of young children waiting to see the doctors. (This means, for instance, talking about the pictures to infants, asking toddlers questions about what is on the page,

and reading with preschoolers.) That the initiative is called "Reach Out and Read," not just "Read" signifies that the goal is to help families get into the habit of sharing a special time with their young children, no matter what the other stresses of life are. The initiative is not about teaching young children to read early. It is about creating an environment that encourages verbal interaction, story telling, and reading in the context of relationships, regardless of the material resources of a family. In fact, special attention is being paid to make sure that Reach Out and Read works for families who themselves may not be able to read, but who can tell stories to their children. Reach Out and Read builds on the reality that for most families, pediatricians are trusted messengers. As one mother said, "Well, if the doctor is giving me books and talking about sharing books with my child, it must be important." It is being implemented in private pediatric practices, in health centers, and in hospital clinics. Boston Medical Center is now also implementing "Sharing Books with Babies," an initiative in collaboration with local child care providers.[13]

Promoting Emotional Wellness Through Early Childhood Mental Health Partnerships

- Focus on staff, child, and family strengths, not on pathologies.
- Use flexible approaches designed to build on community strengths and cultural contexts.
- Place families at the center of the helping, healing process, including them as trainers for new mental health consultants, for example.
- Recognize that mental health skills and perspectives can be a great asset to those working with young children and families.
- Understand that the term "mental health" may turn people off, and therefore use different words.
- Pay attention to the implications of school readiness.

✦ Healthy Steps: A National Demonstration of the Commonwealth Fund

Healthy Steps, a program funded by the Commonwealth Fund in New York, emerged in response to data from a survey conducted by the Fund that found—regardless of class and race—parents feel they do not have enough information about how young children develop. Healthy Steps seeks to strengthen pediatric care by including additional staff as part of the team who have special expertise in child and family development. Their job is to help parents anticipate what will happen as children grow, discuss with them how they can promote healthy child development, and respond to special questions or problems. The child and family developmental specialists also pay attention to parental health and behaviors as these impact on young children. Healthy Steps is being implemented in private pediatric practices, health centers, and clinics as part of the demonstration effort, and a detailed training curriculum has been developed. Implementation sites and a national team are working to find ways to integrate funding for the child development specialists into Medicaid- and State Child Health Insurance Plan (CHIP)-billable frameworks. The extent to which Healthy Steps is a preventive mental health intervention needs to be tested. But clearly, it has the potential to play such a role, as well as to identify families needing more intensive mental health-related interventions in the infant and toddler years.[14]

STRATEGY 4: PROMOTE THE EMOTIONAL WELLNESS OF YOUNG CHILDREN AND THEIR FAMILIES THROUGH A STATEWIDE APPROACH

✦ The Children's Upstream Project (CUPS), Vermont

The State of Vermont has been making a deliberate, sustained, and multi-pronged effort to improve outcomes for young children for a number of years.[15] Now, they are in the process of developing the first statewide early childhood mental health initiative. The catalyst for this effort was a state report that included an estimate by Vermont teachers that about 30 percent of the state's young children lacked the emotional and other skills needed to succeed in school. Armed with this data, the state sought and received funding through the federal Children's Mental Health Services Program to develop a statewide initiative focused on young children and families. The aim is to develop an early childhood mental health system of care that includes prevention, early intervention, and treatment, as well as mechanisms for local and state planning. The name "Children's Upstream Program," or CUPS, was chosen to emphasize the preventive focus of the initiative. It refers to the often-told story of children who are being thrown into a river one after the other; rescuers try to save each of the children as they come downstream, but no one goes upstream to find out who (or what) is throwing them in.

CUPS builds on the existing network of state and regional teams focused on other early childhood issues, such as quality improvement and the development of shared standards across different early childhood settings, as well as on its Starting Points project. It exemplifies how broadly-based partnerships between the early childhood community and mental health, domestic violence, and substance abuse agencies can make a difference. It also stretches the early childhood vision of who should be "at the table" sharing responsibility for promoting the well-being of young children.

The CUPS partnership is paying off in new services and connections. At the community level, this is reflected in increased access to mental health consultants and clinical supervision for child care providers (made possible by using mental health dollars to provide substitute caregivers) and the growth of informal play groups and parent-to-parent support groups with mental health facilitators. For young children who are identified as requiring more intensive services, CUPS has promoted the development of "wraparound" individualized services to them, their families, and their caregivers. (The term "wraparound" in a mental health context means developing an individualized set of support services for families. Most typically it is used in the service of older children and adolescents.) At the state level, CUPS has provided training to family and TANF workers. In partnership with CUPS, the state's Healthy Child Care Vermont coordinator, who sits on the state learning team, is working to develop a "Consultation Tool Kit" to promote early childhood mental health consultation in child care settings. Altogether, through the initiative, over 24 full-time early childhood mental health and related

staff have been hired and trained to work with the early childhood system of care to identify and serve families with young children.

Implementing CUPS has been challenging. Bringing together domestic violence, mental health, and substance abuse agencies involves exploring different organizational cultures and visions; adding a child development and family support perspective makes the task even more complex. Moreover, finding staff with the required range of training and experience is very difficult. At the same time, CUPS is generating real energy across the state, garnering new resources, and seeding new services and collaborations for a group of young children, families, and caregivers whose needs have been too-long ignored. The initiative is being evaluated in a design that deliberately links outcomes with the state's school readiness effort. The state hopes that the pay off will be a visible reduction in the number of children who do not do well on second grade reading tests (now 25 percent), which in turn is a predictor of poor later school performance.

2. Lessons and Implications

Investing in early childhood mental health strategies delivered where the children and families are pays off in more effective, higher quality early childhood, family support, and home visiting programs. Early childhood program directors and staff report that the skills mental health consultants model to help them deal with a specific child also help them improve the way they deal with all children. This translates into overall improvements in the quality of the program. Staff and directors also report that having mental health support available to the program on an on-going basis means that when crises occur (a family death, a staff murder), as they do with increasing frequency, consultants can help the staff, families, and children cope. The presence of skilled mental health workers also means that young children who need more specialized treatment have a better chance of being appropriately identified and connected with services. Home visiting programs with access to mental health expertise report similar experiences.

The attitude and skills of the mental health professionals are key to their effectiveness. Mental health support in the context of early childhood programs will only work if the mental health provider is on staff or on site frequently enough for the staff and families to develop a trusting relationship. An early childhood mental health professional must be especially sensitive to the culture of the program in which he or she is working. Often this involves bridging class, educational, and ethnic differences. It also means understanding and appreciating the skills it takes to be a child care teacher or family child care provider or a home visitor. Competent early childhood mental health professionals have skills that include knowledge of child development coupled with an understanding of family dynamics and psychopathology and an ability to partner with those working directly with the children and families to develop responsive interventions.

Language counts. Many programs have found that the term "mental health" is off-putting, associated with "being crazy," or with labeling and hence stigmatizing children prematurely. Therefore, some programs, even though they may use funds from the mental health system, refer to consultants as advocates or early interventionists. Or, they do not use "mental health" in their project name. CUPS, Day Care Plus, and Motherly Love illustrate this. At the same time, programs also report that once trust is established, it really doesn't matter what name is used.

Building partnerships is essential. In most of the initiatives highlighted, partnerships have emerged that engage one or more systems not usually connected to the early childhood agenda. Typically, mental health boards, county or state mental health

agencies, or community mental health centers have been pivotal. Private foundations have played a leadership role in facilitating these partnerships, especially in the beginning stages, providing both legitimacy and flexible funds.

Creative financing is possible. Funding for early childhood mental health is a challenge, as there are no dedicated federal funds either in early childhood programs or in mental health programs. (In fact, in the latter, the emphasis is on serving only children with the most serious problems.) Notwithstanding this reality, it is clear from the examples above that funding is possible using multiple sources and strategies. As recognition of the urgency of the challenge grows, state children's mental health agencies are also beginning to get involved. For example, Ohio is developing a Request for Proposals to create a network of early childhood mental health consultants who can work with staff and programs.

In general, the hardest two fiscal challenges are: (1) covering the costs of consultation to early childhood staff and (2) paying for interventions for children whose problems are troubling but not severe enough for diagnoses. (Diagnoses are especially difficult to make in young children.) Yet it is in working with staff, and developing early intervention strategies with children whose problems are not yet severe, that early childhood mental health initiatives are likely to have the greatest payoff, especially in terms of school readiness and early school performance. Creating on-going fiscal and other support to ensure these children get the help they need is a crucial challenge for the future.

3. Looking Ahead

The widespread concern about the emotional development of so many young children and the complexity of their family stories, coupled with the emergence of local, and occasionally, statewide strategies across the country augurs well for a more effective response to this group of young children and families. Early childhood mental health strategies can complement, in powerful ways, other equally crucial strategies in the quest to ensure young children and their families quality early childhood experiences across settings. The next section highlights what can be done in communities and at the state level to develop more widespread strategies to promote emotional wellness in young children.

EXPLOITING EXISTING OPPORTUNITIES

There are a number of potential points of both strategic and fiscal leverage that states and communities can use to strengthen an early childhood mental health/emotional wellness agenda. At the state level, collaborations among health, mental health, and child care agencies provide an important place to start. These can include substance abuse and welfare agencies as well. Federal dollars at the state level can also be helpful. For example, through the Maternal and Child Health Bureau's Healthy Child Care grants, every state has a coordinator charged to implement the overall goals of Healthy Child Care America, which include enhancing the mental health of young children in child care settings. In a number of states, addressing mental health issues is a priority for the Healthy Child Care program.[16] Similarly, every state has a Head Start State Collaboration office. Since Head Start has an explicit mandate to meet the mental health needs of its children, it has great potential to be a catalyst in promoting the development of statewide early childhood mental health strategies. Other potential state-level entry points include collaborations between mental health agencies and those administering the growing numbers of statewide home visiting, family support, and other programs for infants, toddlers and preschoolers.[17] States are also in a position to carry out assessments of how Medicaid dollars could better be used for a broad range of early childhood mental health strategies, including consultation, as well as to review state mental health regulations regarding young children and families. And, although there is concern about the long-term sustainability of this strategy, states can at least use

TANF funds to develop and test special early childhood mental health initiatives for low-income children and families in a variety of settings.

CREATING NEW OPPORTUNITIES

At the community level, local early childhood and mental health leaders can explore the need for communitywide initiatives together. In the Day Care Plus evolution, a community forum with child care providers and parents talking about their needs was key to mobilizing the Early Intervention Centers and the county mental health board. Other initiatives, such as San Francisco's High Quality Child Care Mental Health Consultation Program, are trying to use lessons from prior partnerships to expand access more broadly. The pioneering efforts highlighted here and emerging elsewhere across the country provide a wake-up call to the early childhood and mental health communities. The challenge is to ensure that public policies are structured in ways consistent with emerging best practices to promote the emotional well-being of young children, their families, and the staff who nurture and stimulate them.

EVALUATING THE IMPACT OF EARLY CHILDHOOD MENTAL HEALTH INITIATIVES ON SCHOOL READINESS

Several of the sites described in this issue brief have evaluations in progress. However, more systematic and rigorous efforts are needed, with designs that seek to capture the links between school readiness, school performance, early emotional status, and specific early childhood mental health strategies. Additionally, every community needs to ensure that as they develop outcome indicators related to school readiness, proxy measures for young children's emotional well-being are included. This will mean that, over time, communities can assess the extent to which even high-risk young children are prepared to enter school with the emotional and cognitive competencies they need.

4. Conclusion

The strategies highlighted in this issue brief lead to six conclusions.

- No one system has claimed lead responsibility for this group of children; real progress is dependent upon partnerships.
- Building blocks and entry points to develop strategies to promote the emotional well-being of even the most high-risk young children and families—and those who care for and work with them—exist in every community and every state.
- The emerging body of practice knowledge about early childhood mental health strategies provides a basis for other programs and communities to use.
- The policy and funding challenges to making this knowledge and these building blocks work for young children and families cannot be minimized, but creative fiscal and other strategies to sustain the efforts are emerging.
- Additional service system and outcome-related research is crucial, linked to widely shared goals for young children, including emotional readiness for school.
- Paying attention to the emotional well-being of young children, especially the most vulnerable, their families, and their other caregivers is intimately related to ensuring early school success.

Early childhood mental health partnerships that build capacity within the early childhood community to promote the emotional wellness of young children and their families, regardless of the levels of risk they face, as well as to strengthen the skills of staff who work with them, represent a flexible and potentially powerful way of achieving multiple outcomes related to the broader early childhood agenda. The pioneering programs and leaders highlighted in this issue brief are in the vanguard, but what they have done can be replicated by others. Promoting emotional wellness as a core part of the early childhood agenda is a value-added strategy whose time has come.

Appendix A
Project Contact Information

Baltimore City Healthy Start, Inc.
Contact: Barbara Squires
Address: 210 Guilford Avenue, 2nd Floor
Baltimore, MD 21202
Phone: (410) 396-9994
E-mail: bns302@aol.com

California Safe and Healthy Families (Cal-SAHF)
Contact: Terry Eisenberg Carrilio, Ph.D.
Address: San Diego State University,
School of Social Work
College of Health and Human Services
5500 Campanile Drive, Hepner Hall 149
San Diego, CA 92182
Phone: (619) 594-8610
E-mail: TBEAR1009@aol.com

Children's Upstream Project (CUPS)
Contact: Charles Biss
Address: Mental Health Division
103 South Main Street, Weeks Building
Waterbury, VT 05671
Phone: (802) 241-2650
E-mail: cbiss@ddmhs.state.vt.us

Day Care Plus
Contact: Ann Bowdish
Address: Positive Education Program
3100 Euclid Avenue
Cleveland, OH 44105
Phone: (216) 361-4400, ext 20
or (216) 361-7760, ext 120
E-mail: bowdish@pepcleve.org

Free to Grow
Contact: Judith Jones
Address: 60 Haven Avenue, Apt. 1-D
New York, NY 10032
Phone: (212) 304-6425
E-mail: jjones3095@aol.com

Healthy Steps
Contact: Kathryn Taaffe McLearn
Address: The Commonwealth Fund
1 East 75th Street
New York, NY 10021
Phone: (212) 606-3847
E-mail: ktm@cmwf.org

Project BEFORE (Bridging Empowers Families to Overcome Risks and Excel)
Contact: James Rast, Ph.D.
Address: Vroon Associates
(Catalysts for Quality Community Life)
1625 Grand Avenue
Parsons, KS 67357
Phone: (316) 421-3736
E-mail: jrast@terraworld.net

Reach Out and Read
Contact: Perri Klass, Medical Director
Address: Boston Medical Center
1 Boston Medical Center Place, MAT 5
Boston, MA 02118
Phone: (617) 638-3380
E-mail: klass@bu.edu

Sharing Books with Babies: Promoting Literacy Development in Child Care
Contact: Kathleen Fitzgerald Rice
Address: Maternity Building, 5th Floor
Boston Medical Center
One Boston Medical Center Place
Boston, MA 02118
Phone: (617) 414-4475
E-mail: fitzrice@bu.edu

Starting Early Starting Smart (SESS)

Contact: Eileen O'Brien, Senior Enterprise Development Specialist
Address: The Casey Family Program
1808 Eye Street, NW, 5th Floor
Washington, DC 20006-5401
Phone: (202) 467-4441 or (301) 443-6323
E-mail: eobrien@casey.org or eobrien@samhsa.gov
or
Contact: Patricia Solomon
Address: SAMHSA, Office on Early Childhood
U.S. Department of Health and Human Services
5600 Fishers Lane, Room 950, Rockwall II
Rockville, MD 20857
Phone: (301) 443-7762
E-mail: psolomon@samhsa.gov

The High Quality Child Care Mental Health Consultation Initiative, San Francisco

Contact: Carol Stevenson, Director, Starting Points
Address: Mayor's Department of Children, Youth, and Their Families
1390 Market Street, Suite 918
San Francisco, CA 94102
Phone: (415) 554-8427
E-mail: carol@dcyf.org
or
Contact: Sai-Ling Chan-Sew, Director, Child, Youth and Family Services
Address: San Francisco Department of Public Health
Community Mental Health/Children, Youth, and Families
1380 Howard Street, 5th Floor
San Francisco, CA 94103
Phone: (415) 255-3439
E-mail: sai-ling_chan-sew@dph.sf.ca.us

Vermont's Healthy Babies

Contact: Sue Shepard, Healthy Babies Statewide Coordinator
Address: Vermont Department of Health
108 Cherry Street
Burlington, VT 05401
Phone: (802) 652-4174
E-mail: sshepar@vdh.state.vt.us

Appendix B
Resources for More Information

ORGANIZATIONS

Federation of Families for Children's Mental Health

Address: 1021 Prince Street
Alexandria, VA 22314-2971
Phone: (703) 684-7710
Website: www.ffcmh.org
Of special relevance: Parent advocacy for children with emotional and behavioral challenges.

National Head Start Association

Address: 1651 Prince Street
Alexandria, VA 22314
Phone: (703) 739-0875
Website: www.nhsa.org
Of special relevance: Annual institute on mental health in Head Start programs.

National Technical Assistance Center for Children's Mental Health

Address: Georgetown University
Child Development Center
3307 M Street, NW
Washington, DC 20007-3935
Phone: (202) 687-5000
Website: www.georgetown.edu
Of special relevance: Technical assistance related to early childhood mental health.

Zero to Three

Address: 734 15th Street, NW, Suite 1000
Washington, DC 20005
Phone: (202) 628-5790
Website: www.zerotothree.org
Of special relevance: Publications that focus on the emotional well-being of infants and toddlers; also hosts a technical assistance center for Early Head Start.

SELECTED PUBLICATIONS

1. Early Childhood Mental Health Consultation

By Elena Cohen and Roxanne Kaufmann
Available from:
National Technical Assistance Center for Children's Mental Health
Georgetown University Child Development Center
3307 M Street, NW, Suite 401
Washington, DC 20007
Phone: (202) 687-5000 or (800) 899-4301
Fax: (202) 687-1954
Attention: Mary Deacon
E-mail: deaconm@gunet.georgetown.edu

2. Heart Start: The Emotional Foundations of School Readiness

By Zero to Three
Available from:
Zero to Three: National Center for Infants, Toddlers, and Families
734 15th Street, NW, Suite 1000
Washington, DC 20005
Phone: (202) 628-5790 Fax: (202) 638-0851
Attention: Publications Department

3. Mental Health Consultation in Early Childhood

By Paul J. Donohue, Beth Falk, and Anne Gersony Provet
Available from:
Paul H. Brookes Publishing Company, Inc.
P.O. Box 10624
Baltimore, MD 21285-0624
Phone: (800) 638-3775 Fax: (410) 337-8539
Attention: Customer Service

4. Promoting Resilience: Helping Young Children and Parents Affected by Substance Abuse, Domestic Violence, and Depression in the Context of Welfare Reform (Children and Welfare Reform Issue Brief 8)

By Jane Knitzer
Available from:
National Center for Children in Poverty
154 Haven Avenue, 3rd Floor
New York, NY 10032
Phone: (212) 304-7100 Fax: (212) 544-4200
Attention: Publications Assistant
E-mail: nccp@columbia.edu

5. Protecting Young Children in Violent Environments: Building Staff and Community Strengths

Edited by Joy D. Osofsky and Emily Fenichel
Available from:
Zero to Three: National Center for Infants, Toddlers, and Families
734 15th Street, NW, Suite 1000
Washington, DC 20005
Phone: (202) 628-5790 or (800) 899-4301
Fax: (202) 638-0851
Attention: Publications Department

Endnotes

1 This issue brief draws heavily on the following: Yoshikawa, H. and Knitzer, J. *Lessons from the Field: Head Start Mental Health Strategies to Meet Changing Needs.* New York, NY: National Center for Children in Poverty, Mailman School of Public Health, Columbia University, 1997; Knitzer, J. *Promoting Resilience: Helping Young Children and Parents Affected by Substance Abuse, Domestic Violence, and Depression in the Context of Welfare Reform* (Children and Welfare Reform Issue Brief 8). New York, NY: National Center for Children in Poverty, Mailman School of Public Health, Columbia University, 2000; and Knitzer, J. "Early Childhood Mental Health Services: A Policy and Systems Development Perspective." In: J.P. Shonkoff and S. J. Meisels (Eds.), *Handbook of Early Childhood Intervention, 2nd edition.* New York, NY: Cambridge University Press. 2000: 416-438.

2 Emotional growth continues throughout the life span, and each phase brings new tasks and new capacities, but the early years are especially important. One cornerstone of mental health—the ability to form secure attachments—is laid in the early years of life. Within the context of secure relationships, children are better able to meet the developmental tasks of early childhood, which include moving from other-regulation to self-regulation (including emotional self-regulation), beginning to develop a sense of self, and internalizing rules and a sense of right and wrong. See Beckwith, L. "Prevention Science and Prevention Programs." In: C. H. Zeanah, Jr., *Handbook of Infant Mental Health, 2nd edition.* New York, NY: Guilford Press, 2000: 439-456.

3 See endnote 1.

4 Coyle, J. T. "Psychotropic Drug Use in Very Young Children." *Journal of the American Medical Association,* 283 (2000): 1059. Zito, J. M., Safer, D. J., dosReis, S., Gardner, J. F., Boles, M., and Lynch, F. "Trends in the Prescribing of Psychotropic Medications to Preschoolers." *Journal of the American Medical Association,* 283 (2000): 1025.

5 See endnote 1.

6 See Knitzer "Early Childhood Mental Health Services" in endnote 1.

7 See, for example, Aber, J. L. "Poverty, Violence, and Child Development: Untangling Family and Community Level Effects." In: C. A. Nelson (Ed.), *Threats to Optimal Development: Integrating Biological, Psychological, and Social Risk Factors* (Minnesota Symposium On Child Psychology Vol. 27). Hillsdale, NJ: Lawrence Erlbaum, 1994: 229-272; and Brooks-Gunn, J., Duncan, G., Klebanov, P. K., and Sealand, N. "Do Neighborhoods Influence Child and Adolescent Behavior?" *American Journal of Sociology,* 99 (1993): 353-395.

8 See Donahue, P. J., Falk, B., and Provet, A. G. *Mental Health Consultation in Early Childhood.* Baltimore, MD: Paul H. Brookes, 2000; and Cohen, E. and Kaufmann, R. *Early Childhood Mental Health Consultation.* Washington, DC: U.S. Department of Health and Human Services, Center for Mental Health Services (CMHS), and Substance Abuse and Mental Health Services Administration (SAMHSA), 2000.

9 For example, NCCP's *Map and Track* series found many states supporting home visiting programs. The Packard report on research on home visiting programs, in general, found disappointing results overall, although there was only limited analysis of the extent to which the program served the kinds of high-risk families that are the focus of this discussion. See Knitzer, J., and Page, S. *Map and Track: State Initiatives for Young Children and Families.* New York, NY: National Center for Children in Poverty, Mailman School of Public Health. 1998. A 2000 edition is in progress (see www.nccp.org); and Gomby, D. S., Culross, P. L., and Behrmann, R. E. "Home Visiting: Recent Program Evaluations." *The Future of Children,* 9(1) (1999): 4-26.

10 Carrillio, T. E. *California Safe and Healthy Families: A family support home-visiting model; executive summary.* San Diego, CA: School of Social Work Policy Institute, San Diego State University. 1998.

11 For a fuller discussion of this see Knitzer *Promoting Resilience* in endnote 1.

12 Rast, J. *Lessons from the Village (What I Have Learned From the Community About Early Intervention and Prevention).* Parsons, KS: KanFocus, 1997.

13 For more information see: *Reach Out and Read Program Manual, 2nd edition,* April 1999 and Boston Medical Center. *Reach Out and Read: A national pediatric literacy program.* April 1999. www.reachoutandread.org.

14 The Commonwealth Fund. *Health Steps for Young Children Program. A National Initiative to Foster Healthy Growth and Development.* New York, NY: The Commonwealth Fund, 1999. www.healthysteps.org.

15 The state has regional networks of Healthy Babies home visiting programs, parent-child centers, a deliberate strategy to link welfare reform implementation (including outreach to noncustodial fathers) with improving outcomes for young children, and an outcome-driven set of regional indicators used for planning. See endnote 14.

16 Rafanello, D. "Partnerships to Promote Mental Health." *Healthy Child America,* Fall (1999): 3-11.

17 See endnote 1.

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Starting Points

This brief was created as part of **Carnegie Corporation of New York's Starting Points State and Community Partnerships for Young Children**. Starting Points was established to plan and implement the reforms described in the Corporation's task force report, *Starting Points: Meeting the Needs of Our Youngest Children*. The four goals of the initiative are promoting responsible parenthood, ensuring high quality child care, providing children with good health and protection, and mobilizing the public to support young children and families. Starting Points sites are Baltimore, Boston, Pittsburgh, San Francisco, Colorado, Florida, Hawaii, North Carolina, Rhode Island, Vermont and West Virginia. National partners include The Finance Project **(www.financeproject.org)**, Columbia University School of Public Health **(www.columbia.edu)**, the National Center for Children in Poverty **(www.nccp.org)**, and the Families and Work Institute **(www.familiesandwork.org)**. More information about Carnegie Corporation can be found at **www.carnegie.org.**

National Center for Children in Poverty

The National Center for Children in Poverty (NCCP) was established in 1989 at the Mailman School of Public Health, Columbia University, with core support from the Ford Foundation and the Carnegie Corporation of New York. Its mission is to identify and promote strategies that reduce the number of young children living in poverty in the United States, and that improve the life chances of the millions of children under age six who are growing up poor. For more information, visit NCCP's website at **www.nccp.org.**

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