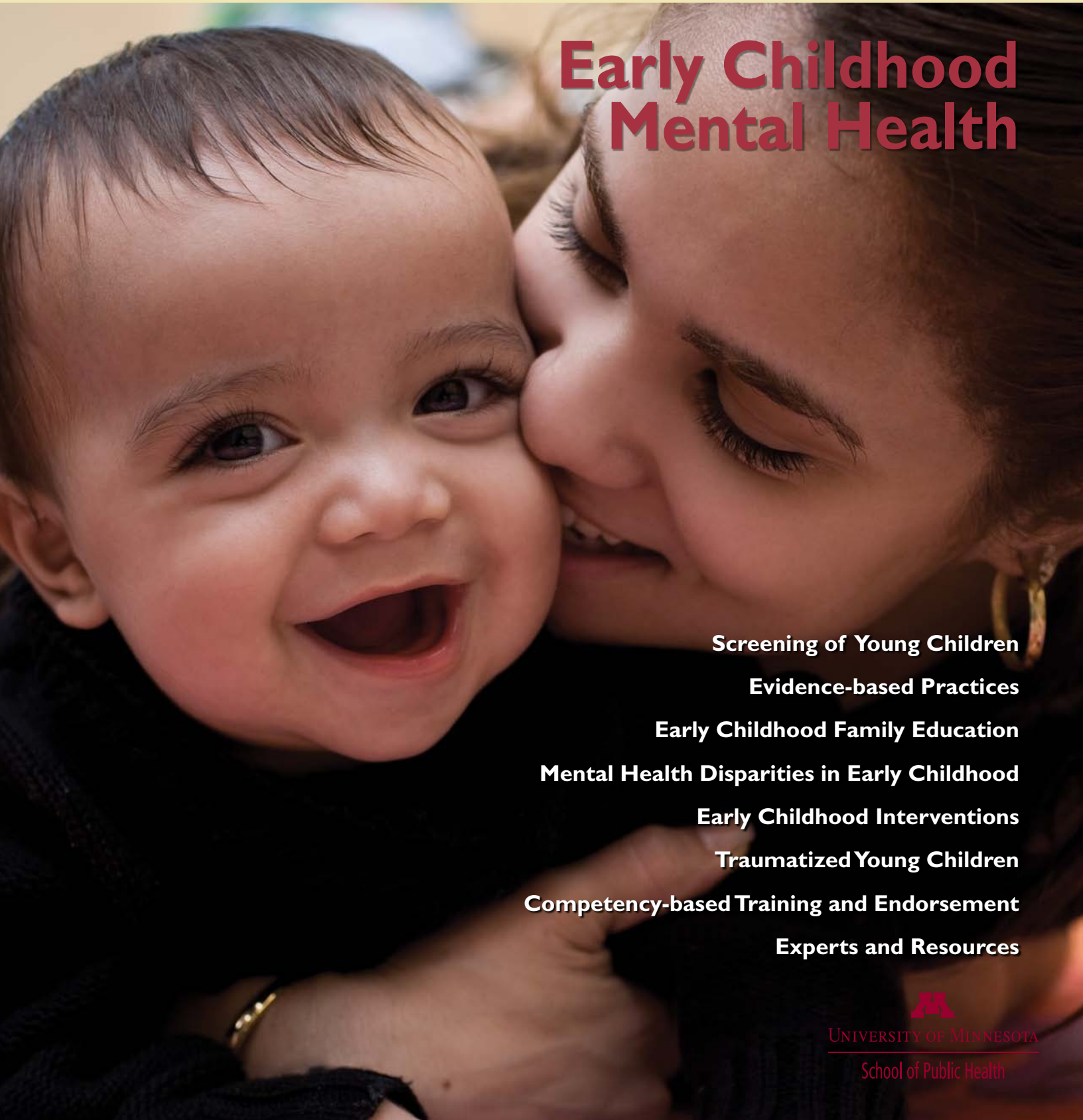
A publication of the Center for Leadership Education in Maternal and Child Public Health

Healthy Generations

Winter 2009-2010



Early Childhood Mental Health

Screening of Young Children

Evidence-based Practices

Early Childhood Family Education

Mental Health Disparities in Early Childhood

Early Childhood Interventions

Traumatized Young Children

Competency-based Training and Endorsement

Experts and Resources

University of Minnesota
School of Public Health

Early Childhood Mental Health

Winter 2009-2010

IN THIS ISSUE

The Center for Leadership Education in Maternal and Child Public Health is committed to improving the health of children, women and families. Center faculty and staff offer a Master's degree in Public Health (including an online degree program), continuing professional education, and consultation and technical assistance to community- based organizations and agencies. Center faculty are involved in intervention and etiologic research in child health, adolescent health, family health, health disparities, reproductive health, and women's health. See our web site at www.epi.umn.edu/mch.

Healthy Generations is produced with support from the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services (grant numberT76-MC00005-55)

Contact: mch@umn.edu or (612) 626-8644

Graphic design/art direction: Carr Creatives (www.carrcreatives.com)

LETTER FROM THE EDITORS

In this issue of Healthy Generations*, we focus on the mental health of young children, ages birth to five. We are aware that this domain of early childhood has too often been overlooked—only recently drawing considerable professional attention. Why this lack of attention? Perhaps too many have believed that young children, especially infants, cannot experience mental health problems. Infants who cry inconsolably or preschoolers who show excessive biting have often been viewed as "going through a stage" that they will outgrow. This dismissive attitude fits the societal stereotype about mental health problems in general; that is, the tendency to ignore such challenges because a parent or caregiver does not know what to do, or worse, fears being blamed for their young child's behavior. Dramatic advances in our understanding of early brain development, the critical importance of social environments that stimulate and nurture, and the untoward consequences when relationships to provide this care are absent or unpredictable have taught us that the developmental trajectory towards positive mental health begins early. We now know what can and MUST be done to ensure that ALL infants and young children receive what they need from their caregiving environments to develop into happy, healthy children with positive mental well-being who grow into productive, contributing members of our society.*

We want to thank the many professionals who contributed to this volume and shared their expertise about early childhood mental health. We are excited to see that public health thinking is being brought to bear in assuring the mental health of our young children. To present a balanced perspective—promoting positive mental health with attention to mental health problems—we invited articles that provide examples of interventions that promote mental health, prevent problems in high-risk groups, as well as interventions that treat diagnosed mental health disturbances—in all cases, emphasizing evidence-based practice. Other articles in this volume highlight cutting edge issues related to early childhood mental health—screening and diagnostic assessment, collaborative efforts to develop early childhood and mental health systems of care, and workforce training initiatives in Minnesota.

We are keenly aware of the need for policies that provide public support for the programs and interventions described in this issue, as well as policies that assure the social conditions that enable families and communities to create nurturing, supportive contexts where children's mental health can flourish.

We are pleased to showcase the wealth of information and strength of resources presented by our professional colleagues in Minnesota. We are also very proud to share with our readers several articles written by graduates of our Maternal and Child Health Program at the University of Minnesota, who are leaders in this field. As we finalized this volume, we read, with sadness, that Norman Garmezy died on November 21, 2009. Dr. Garmezy, a Professor Emeritus of Psychology at the University of Minnesota, was considered the "grandfather of resilience theory." Among the many findings of Dr. Garmezy and his colleagues was that good relationships with adults exert an effect that is as powerful—or even more powerful—than the mitigating effects of adversity on child mental health. His work furthered our understanding of how children can flourish in adverse environments and continues to stimulate researchers at the University of Minnesota and across the globe.

As always, we welcome your feedback about this issue as well as topics for subsequent issues.

—Joän Patterson, PhD, LP, Julia Johnsen, MPH, and Wendy Hellerstdt, MPH, PhD

A Public Health Approach to Early Childhood Mental Health

Balancing Mental Health Promotion and Treatment for Mental Health Problems

Joän M. Patterson, PhD, LP

Infants, toddlers, and preschoolers can—and do—experience significant mental health problems. Untreated, these problems may adversely affect multiple developmental domains, and in turn, a child's school performance, social competence, and even adult health. Furthermore, mental health problems that emerge in early childhood are not simply outgrown; in many cases, they persist into adolescence and adulthood due to impairments embedded in early brain structure that lead to heightened physiological reactivity when exposed to subsequent adversity (see Gunnar, page 5).

"Parents and other regular caregivers in children's lives are 'active ingredients' of environmental influence during the early childhood period. Children grow and thrive in the context of close and dependable relationships that provide love and nurturance, security, responsive interaction, and encouragement for exploration. Without at least one such relationship, development is disrupted and the consequences can be severe and long lasting."

— National Research Council and Institute of Medicine, page 7.[4]

Defining Early Childhood Mental Health

In young children, mental health is often equated with healthy social and emotional development, which is defined as "the developing capacity of the young child to experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn, in the context of a caregiving environment that includes family, community, and cultural expectations for young children."[1] Noteworthy in this definition is the emphasis on positive mental health, which contrasts with the tendency to focus on mental health problems in older children, adolescents, and adults.

Assessing Prevalence of Mental Health Problems

There are limited data for estimating the number of young children who experience serious mental health disturbances, which is related to several challenges in conceptualizing and measuring mental impairment in this age group:

- First, given the rapid pace of development in the early years, there is wide variation in what constitutes normal social and emotional development, making it difficult to assign boundaries between normative development and at risk, problematic, or clinically significant impairment;
- Second, a young child's mental health can best be understood in terms of his/her primary relationships with caregiver(s) in the context of family, culture, and community; these contextual factors are not considered in diagnostic schemes that are used for older children and adults; and
- Third, there is not yet consensus on the diagnostic criteria for classifying psychiatric impairment in young children.[2]

However, awareness of social, emotional, and behavioral problems in young children is increasing, as reflected in the growing number of young children who are expelled from preschool.[3] A limited number of studies of psychiatric disorders (e.g., anxiety disorders, disruptive behavior disorder, attention deficit/hyperactivity disorder, and depression) have reported prevalence rates in preschool children ranging from 14% to 26%, which are similar to rates reported for school-age children.[2] Newer diagnostic schemes, developed specifically for birth to three years (see page 10), emphasize relationship disorders and stress-related disorders resulting from exposure to environmental stressors, but prevalence rates have not yet been reported.

Determinants of Mental Health in Young Children

Determinants of mental health for the birth to 5-year-old population include biological, geographical, social, and economic factors associated with both positive mental health and mental health problems.

The quality of early relationships is the most fundamental determinant of healthy social-emotional development in infants and toddlers. A secure attachment to a primary caregiver has an enduring influence on the mental health of young children. Relationships with parents (and other caregivers) need to be nurturing, protective, consistent, and characterized by high sensitivity to infant cues.

Biological factors within the infant, such as a difficult temperament or premature birth and low birth weight, may pose a challenge to some parents' abilities to respond sensitively to infant cues and develop a nurturing relationship.

The mental health of parents and caregivers is another major determinant of infant mental health because it influences the caregivers' capacity to be nurturing and responsive to their infants and provide adequate stimulation for learning. Untreated postpartum depression in mothers is a recognized risk factor affecting infants' social-emotional development.[4] Among child care workers, higher rates of depression have been reported compared to adults in the general population.[5]

Social environment. Other factors in the social environment that can undermine high quality early relationships and put young children at risk for mental health problems include violence in the home or neighborhood, intense marital discord, parental substance abuse, and child abuse and neglect. The effects of these exposures in infants and young children may manifest in behaviors such as excessive and inconsolable crying; a heightened sensitivity to touch and cuddling; excessive biting, kicking and hitting; inability to focus on activities; flat affect (no emotive expressions); and/or depression.

Poverty. Many of the aforementioned risks are confounded by living in a family experiencing persistent poverty. Children from low-income families show higher rates of emotional and behavior problems.[6] Because children of color are disproportionately represented among low-income families, they are reported to experience poorer social-emotional development. Poor, minority children also are more likely to be in the child welfare system—another setting where higher rates of social, emotional, and behavior problems in young children are found.[7]

However, when any of these determinants are identified early, at-risk children and their caregivers can receive interventions and support that can buffer mental health problems and lead to positive emotional and social developmental outcomes.

A Framework to Guide Mental Health Interventions

Georgetown University, with support from the Substance Abuse and Mental Health Services Administration (SAMHSA), recently released a monograph that draws on public health values, principles, and functions to advance an intervention model for children's mental health.[8]

Differentiating positive mental health from mental health problems. Unlike the historical emphasis on preventing and treating mental health problems in children and adolescents, this new intervention model proposes a balanced focus between positive mental health and mental health problems. Positive mental health is viewed along a continuum that is independent of the continuum of mental health problems.[8] The absence of a mental health problem does NOT indicate positive mental health, nor does having a diagnosable mental illness prevent a child from experiencing social-emotional well-being. The emphasis on optimizing positive mental health draws from recent psychological literature that describes persons who are "flourishing" in contrast to "languishing,"[9] and from a recent Institute of Medicine report emphasizing "developmental competencies" in children.[10] Emphasis on positive mental health is also congruent with public health's focus on health promotion (and disease prevention), and infant/toddler mental health professionals emphasis on the promotion of social and emotional competencies in young children.

Categories of interventions. In the Georgetown model, interventions are not restricted to preventing and treating mental health problems, but include interventions to promote positive mental health as well. Interventions are grouped into four domains:

- ***Promoting*** and optimizing positive mental health in ALL children by assuring that the determinants of positive mental health are present (e.g., Early Child and Family Education programs to support parents in how to engage in nurturing, consistent relationships with their babies—see page 15);
- ***Preventing*** mental health problems in young children, especially those known to be at risk due to exposure to any of the determinants of mental health problems (e.g., home visiting—see page 19);
- ***Treating*** diagnosed mental health problems as early as possible to diminish or end the effects of the identified problem (e.g., the *Incredible Years* program for young children with conduct disorders—see page 26); and
- ***Re/Claiming*** health for those children who have been or continue to be treated for mental health disorders so they can develop and experience mental well-being even in the context of managing their mental health problem.

Nearly all of the interventions include a focus on the quality of the young child's early relationships with parents/caregivers. Viewing a child alone as the source of the problem, without considering his/her relationships, can lead to ineffective intervention practices. Although examples for each category of intervention are described throughout this issue, many fit

Continued on page 4

more than one category. It is important to remember, however, that assessing the outcomes of an intervention requires a shift in focus when selecting indicators for positive mental health (e.g., social skills or emotional regulation) versus mental health problems (e.g., reduction in anxiety symptoms).

A Mental Health Systems Approach

Families are embedded in multiple systems within their cultures and communities that ideally are equipped to support them in meeting their children's emotional needs by providing education and support and by identifying social-emotional problems in young children early through screening in naturalistic settings (see page 7) which can be followed by diagnostic assessment (see page 10) and treatment when needed. The mental health system alone cannot accomplish this goal; it requires coordination with other systems—education, child care, nutritional programs, and healthcare—to ensure that young children receive what they need to promote positive mental health and to identify and treat problems when they occur. Wright (page 11) describes the mental health system in Minnesota and Monson (page 30) describes a comprehensive early childhood system in Minnesota that includes mental health as one of several domains that intersect to ensure healthy development in young children.

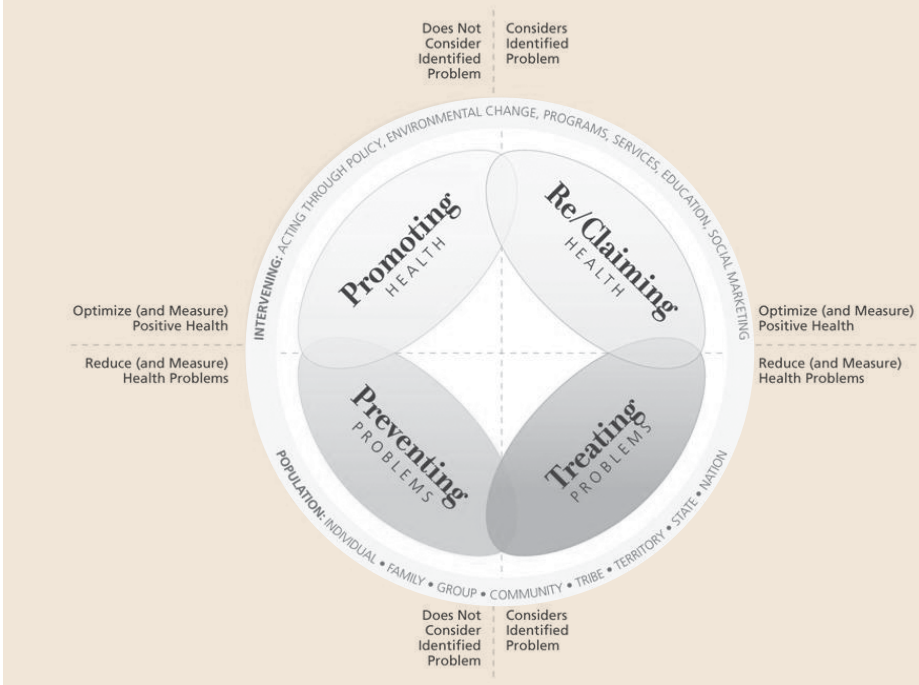
Role of Public Policies in Assuring Early Childhood Mental Health

Awareness of the determinants of positive mental health and mental health problems point to the importance of assuring the social conditions that will contribute to the ability of parents and families to engage in nurturing relationships with young children and to provide adequate stimulation and experiences for learning. It is the role of public policies to assure that those social conditions exist.

Training. As our awareness of the mental health needs of young children has increased, we are confronted with the dearth of clinicians who are trained to screen, diagnose, and treat infants, toddlers and preschool children with mental health problems. In one study, it was estimated that between 80–90% of 3–5-year-olds with identified mental health needs did not receive services.[11] In Minnesota, inroads are being made to expand early childhood mental health training across the state (see Kragthorpe page 33 and Carlson page 34).

There is a growing recognition that the trajectory to success, both in school and in later life, begins in the early years. What happens during the first three years of life can lay the foundation for becoming a productive, mentally healthy, contributing member of society, or it can lay the foundation for intergenerational cycles of abuse, neglect, violence, dysfunction, and mental illness. The burgeoning science of early brain development points to the wisdom of investing resources "early" in a child's developmental trajectory, beginning *in utero* to eliminate toxic exposures that compromise brain development, and then assuring the social conditions that support and contribute to high quality nurturing and responsive parent-infant relationships.[5,10] Meeting the mental health needs of all young children and families through careful planning, integration of services and supports, and the full participation of families, providers, and other community members makes good economic sense and helps assure good outcomes for our children, their families, and our communities.

INTERVENING MODEL FOR CHILDREN'S MENTAL HEALTH[6]



REFERENCES

1. Zero to Three Infant Mental Health Steering Committee. Definition of infant mental health. Washington, D.C.: Zero To Three; 2001. Available from: http://www.zerotothree.org
2. Egger HL, Angold A. Common emotional and behavioral disorders in preschool children: prevention, nosology, and epidemiology. J Child Psychol Psychiatry 2006; 47:313-337.
3. Gilliam W. Prekindergarteners left behind: explusion rates in stae prekindergarten systems. New Have, CT: Yale University Child Study Center, 2005.
4. National Research Council and Institute of Medicine. From neurons to neighborhoods: the science of early childhood development. Shonkoff JP, Phillips DA (editors). Washington DC: National Academy Press, 2000.
5. Whitebook M, Phillips D, Bellm D, et al. Two years in early care and education: A community portrait of quality and workforce stability. Berkeley, CA: Center for Study of Child Care Employment, U of CA at Berkeley, 2004.
6. Duncan GJ, Brooks-Gunn J. Family poverty, welfare reform and child development. Child Dev 2000; 71:188-196.
7. Burns B, Phillips S, Wagner H, et al. Mental health need and access to mental health services by youths involved with child welfare. A national survey. J Am Acad Child Adolesc Psychiatry 2004; 43:960-970.
8. Miles J, Espiritu R, Horen N, Sebian J, Waetzig E. A public health approach to children's mental health: a conceptual framework. Washington DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health, 2009.
9. Keyes C. Promoting and protecting mental health as flourishing. Am Psychol 2007; 62(2):95-108.
10. National Research Council and Institute of Medicine. Preventing mental, emotional and behavioral disorders among young people: progress and possibilities. Washington DC: National Academies Press, 2009.
11. New M, Razzino B, Lewin A, et al. Mental health service use in a community Head Start population. Arch Pediatr Adolesc Med 2002; 156:721-727.

Joän Patterson, PhD, LP, is an Associate Professor in the Maternal and Child Health Program in the School of Public Health at the University of Minnesota.

Early Experience and the Science of Brain Development

Megan R. Gunnar, PhD, and the National Scientific Council on the Developing Child

Science tells us that what happens in early childhood can enhance or impair the health and productivity of society. Research on the biology of stress in early childhood shows how major adversity, such as extreme poverty, abuse, or neglect, can weaken developing brain architecture and alter the body's immune system in ways that risk the individual's adult physical and mental health. Science also shows that providing stable, responsive, nurturing relationships in the earliest years of life can prevent or even reverse the damaging effects of toxic stress, with lifelong benefits for learning, behavior, and health. This conclusion is based on the following series of core principles derived from decades of scientific research.

Brains Are Built Over Time from the Bottom Up

The construction of the brain's architecture begins before birth and continues to be refined into early adulthood. Brain systems that perceive sensation (e.g., hearing, touch) and simple actions develop first, followed by systems that are involved in emotions, more complex actions, and early language. Later-developing systems support increasingly complex thinking, reasoning, planning, and self-control. As each brain system develops, it is built on top of earlier-developing systems and can be only as good as the architecture on which it is built. Early experiences affect whether a child's brain architecture will provide a sturdy or fragile foundation for all of the learning and development that will follow.

Interactive Influences of Genes and Experience Shape the Developing Brain

It is not just one's genetic makeup, but how those genes get used, that determines brain development. Once the child is born, experiences influence how genes are turned on and off and thus how they are used. One important example of this process is the "serve and return" nature of children's relationships with adults. Young children naturally reach out for interaction through babbling, facial expressions, and gestures. Adults respond with the same kind of vocalizing and gesturing back at them. In the absence of such responses—or if the responses are unreliable or inappropriate—the child's brain architecture does not form as expected, which can lead to disparities in learning and behavior.

The Brain's Capacity for Change Decreases with Age

The brain is most flexible, or "plastic," early in life. As the maturing brain becomes more specialized to assume more complex functions, it is less capable of reorganizing and adapting to new or unexpected challenges. For example, by the first year, the parts of the brain that differentiate sound are becoming specialized to the language the baby has been exposed to. At the same time, the brain is already starting to lose the ability to recognize different sounds found in other languages. Although the "windows" for language learning and other skills remain open, these brain

Continued on page 6

circuits become increasingly difficult to alter over time. Early plasticity means it is easier and more effective to influence a baby's developing brain architecture than to rewire parts of its circuitry in the adult years.

Cognitive, emotional, and social capacities are inextricably intertwined throughout the life course. *The brain is a highly integrated organ, and its multiple functions operate in a richly coordinated fashion. Emotional well-being and social competence provide a strong foundation for emerging cognitive abilities, and together, they are the bricks and mortar that are prerequisites for success in school and later in the workplace and community.*

Chronic Stress Can Be Toxic to Developing Brains

Learning how to cope with threat and challenge is an important part of healthy development. When we are threatened, our brains activate a variety of physiological responses, which together are called "stress biology." When a young child is protected by supportive relationships with adults, she/he learns to cope with everyday challenges and the child's stress response systems quickly return to baseline. Scientists call this ***positive stress.*** ***Tolerable stress*** occurs when more serious difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury, are buffered by caring adults who help the child adapt, which mitigates potentially damaging biological stress reactions. When strong, frequent, or prolonged adverse experiences such as extreme poverty or repeated abuse are experienced without adult support and intervention, stress becomes toxic as the biology of stress begins to damage developing brain circuits.

Significant Early Adversity Can Lead to Lifelong Problems

Toxic stress in early life and common precipitants of toxic stress—such as poverty, abuse or neglect, parental substance abuse or mental illness, and exposure to violence—can have a cumulative toll on an individual's physical and mental health. (The more adverse the experiences are in childhood, the greater the likelihood of developmental delays and other problems.) Adults who had a greater number of adverse experiences in early childhood are also more likely to have health problems, including alcoholism, depression, and heart disease.

Early Intervention Can Prevent the Consequences of Early Toxic Stress

Research shows that later interventions are likely to be less successful—and in some cases ineffective. For example, when children who experienced extreme neglect were placed in the care of responsive and supportive parents before age two, their IQs increased more substantially and their brain activity and emotional relationships were more likely to become normal than if they were placed after the age of two. While there is no "magic age" for intervention, it is clear that, in most cases, intervening as early as possible is significantly more effective than waiting.

Stable, Caring Relationships Are Essential for Healthy Development

Children develop in an environment of relationships that begins in the home and includes extended family members, early care and education providers, and members of the community. Studies show that children who develop in a context of secure, trusting relationships are better adjusted when they get to school, do better in school, stay in school longer, become more productive and healthier members of the workforce as adults and are better equipped to support the healthy development of the next generation. Numerous scientific studies support the conclusion that providing supportive, responsive relationships as early in life as possible enhances future prosperity and can prevent or reverse the damaging effects of toxic stress.

This article is based on the collective work of the National Scientific Council on the Developing Child. Working papers with scientific citations for the research studies referred to can be found at their website: http://developingchild.harvard.edu/initiatives/council/

Megan R. Gunnar, PhD, is a Regents Professor and Distinguished McKnight University Professor in the Institute of Child Development at the University of Minnesota. She is a member of the National Scientific Council on the Developing Child.

Social-Emotional Developmental Screening of Young Children

The First Step in Identifying Mental Health Problems

Troy Hanson, MD, and Joän Patterson, PhD, LP

Social and emotional developmental screening is an essential component in the early identification of mental health problems in young children. Ideally, screening occurs with ALL children when there are no symptoms present, long before an infant's or young child's development and functioning are impaired.

Why Is Screening Important?

Problems or delays in early social-emotional development represent the precursors of what can become a maladaptive mental health trajectory. Research in developmental psychopathology draws attention to the cascading effects of untreated problems that often adversely affect realms of functioning at a tremendous cost to the child, his/her family, and society.

It is estimated that one in three children ages 3–5 years fail to meet age-appropriate social and emotional developmental milestones.[1] Early identification of these social-emotional problems and subsequent diagnostic assessment can direct young children and families toward effective, evidence-based early interventions, which provide an amazing opportunity to positively alter mental health trajectories and improve mental health outcomes throughout the life course. If these delays are not found early, a child misses the opportunity for early interventions.

What Is Social-Emotional Developmental Screening?

Social-emotional screening is designed to identify children who should receive more intensive assessment and diagnosis for potential delays in social-emotional development. Screening should *not* be done to label a child and it does not provide a diagnosis. Rather, screening is the first step toward the possibility of a diagnosis. Ideally, screening is done using a standardized tool to identify social-emotional concerns or problems. Most general developmental screening tests that are designed to assess other domains—such as cognitive or motor development—do *not* adequately capture social and emotional development. Thus separate instruments have been designed to identify children who are at risk of social-emotional problems.

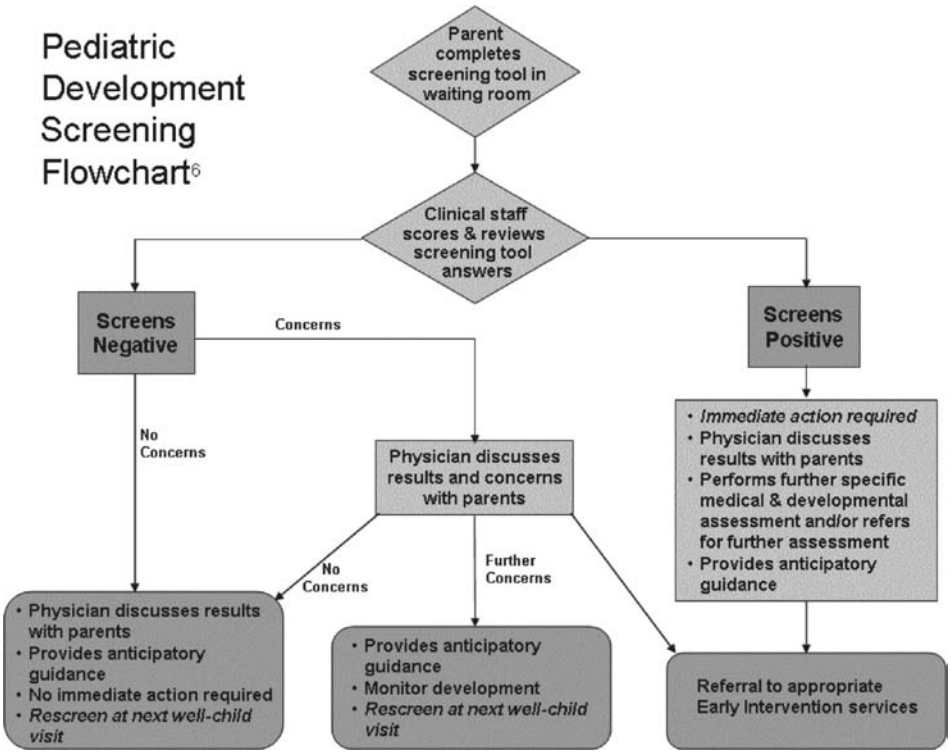
Choosing a social-emotional screening instrument. A screener, first of all, should be easy for a parent to complete in a short amount of time (30 minutes or less). It should have norms for specific age groups tested; demonstrate good reliability, validity, sensitivity, and specificity; and have written procedures for administration, scoring, and interpretation. The screener should be culturally sensitive for diverse populations, including those for whom English is a second language. Three screening tools that meet these criteria are recommended by the Minnesota Interagency Developmental Screening Task Force[2] (see the box). The *Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)*[3] is the social-emotional screening tool most widely used by providers in multiple settings.

Settings for Developmental Screening

Early identification of social-emotional delays or problems necessitates that screening occurs in settings regularly accessed by infants, young children, and their families, and where such screening is perceived as appropriate and acceptable.

The ***primary health care setting*** is one of those regularly accessed settings because 14 health supervision visits are recommended for children between birth and 5 years.[4]

Continued on page 8



SOCIAL-EMOTIONAL DEVELOPMENT SCREENING INSTRUMENTS

Ages and Stages Questionnaire–Social-Emotional (ASQ-SE)[1]

Parent report (5th grade reading level)

Time: 10–15 minutes to complete; 1–3 minutes to score
Child ages: 6, 12, 18, 24, 30, 36, 48 & 60 month intervals
Sensitivity: 71–85% **Specificity:** 90–98%
Available in English, Spanish
Areas assessed: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people

Pediatric Symptom Checklist (PSC)[2]

Parent report (5th grade reading level)

Time: 2–12 minutes to complete
Child ages: 4–16 years
Sensitivity: 88–92% **Specificity:** 68–99%
Available in English, Spanish, Chinese
Area assessed: psychosocial dysfunction

Brief Infant-Toddler Social Emotional Assessment (BITSEA)[3]

Parent report (5th grade reading level) 7–10 minutes to complete

Child ages: 12–36 months
Sensitivity: 80–99% **Specificity:** 80–89%
Available in English, Spanish
Areas assessed: internalizing problems, externalizing problems, disregulation, and competence

REFERENCES

1. Beligere N, Bandepalli C, Helin R, et al. Parents report of social and emotional status of the premature infants. Ages and Stages Questionnaire (ASQ) on Social and Emotional (S/E) Assessment ASQ:SE. J Dev Behav Pediatr 2005; 26(6):472.

2. Jellinek MS, Murphy JM, Little E, et al. Use of the Pediatric Symptom Checklist to screen for psychosocial problems in pediatric primary care: a national feasibility study. Arch Pediatr Adolesc Med 1999; 153:254-260.

3. Briggs-Gowan MJ, Carter AS, Irwin JR, et al. The Brief Infant -Toddler Social and Emotional Assessment: screening for social-emotional problems and delays in competence. J Pediatr Psychol 2004; 29(2):143-55.

Even with this relatively high number of potential contacts with health professionals, it is estimated that only 20–40% of "at-risk" or "pre-impaired" children are appropriately identified during this period of peak neural plasticity or receptivity to change.[1]

Barriers to early identification in primary care. There are many reasons why so many young children "fall through the cracks" and remain unidentified during health supervision visits—but one of the significant factors is failure to use a standardized, validated screening tool. Too many providers use their subjective judgment about whether a young child has social-emotional problems. When an empirically validated social-emotional developmental screening tool is systematically employed, accurate detection rates of social-emotional problems increase to 70–80%.[5]

Many parents believe that their child cannot have a mental health problem, or that he or she will "outgrow" disruptive behavior problems, extreme shyness or anxiety, excessive irritability, difficulty in forming friendships, and so on. These societal attitudes are rooted in the stigma associated with mental illness generally, as well as a lack of mental health knowledge and awareness among some parents, child care professionals, and even health providers.

The Centers for Disease Control and Prevention provide guidelines for health providers when interpreting screening results (see chart).[6] Screening itself can be an intervention when results are reviewed with the parent/caregiver and strengths as well as possible delays are discussed. In addition, anticipatory guidance can alert parents about what to watch for and do at home to foster healthy development.

Child care and early education settings are another regularly accessed setting used by families of infants and young children. Head Start and Early Head Start now require screening for social-emotional development. However, there is a need to advocate for the integration of screening into other child care and education settings. In these settings, barriers to screening may include lack of training and expertise in child development for some providers, lack of access to early childhood mental health consultants, and lack of resources to implement screening.

Other settings where screening occurs. As described in other articles in this issue, there are several additional settings where screening of infants and young children regularly occurs: the Follow Along Program, home visiting, Early Childhood Family Education, and child welfare visits. Early childhood screening is required for public school entrance and is usually done at ages 3 to 4. Both observation and parent report are required.

Early childhood social and emotional developmental screening represents an important component of a public mental health agenda and a necessary step toward improving the life course for mental health and public health outcomes. It should remain a priority for future public health efforts and policy.

REFERENCES

1. Shonkoff J, Phillips D. (Eds.). National Research Council and Institute of Medicine. From neurons to neighborhoods: the science of early childhood development. Washington, DC: National Academy Press, 2000.
2. Developmental and social-emotional screening of young children in Minnesota. Developmental and social-emotional screening instruments. Minnesota Department of Health. Available from: http://www.health.state.mn.us/divs/fh/mch/devscrn/instruments.html
3. Beligere N, Bandepalli C, Helin R, et al. Parents report of social and emotional status of the premature infants. Ages and Stages Questionnaire (ASQ) on Social and Emotional (S/E) Assessment ASQ:SE. J Dev Behav Pediatr 2005; 26(6):472.
4. Hagan JF, Shaw JS, Duncan PM, eds. Bright futures: guidelines for health supervision of infants, children and adolescents, 3rd edition. Elk Grove Village, IL: American Academy of Pediatrics, 2008.
5. Meisels SJ, Atkins-Burnett S. Developmental screening in early childhood: a guide (5th ed.). Washington, DC. National Association for the Education of Young Children, 2005.
6. Pediatric screening developmental flow chart. Available from: http://www.cdc.gov/ncbddd/child/screen_provider.htm#chart

Troy Hanson, MD, is a board-certified family medicine physician who works in several rural clinics and emergency departments in Minnesota. Dr. Hanson is a graduate student in the MCH MPH program. He also completed the Infant Mental Health certificate program in the University of Minnesota's Institute of Child Development.

Joän Patterson, PhD, LP, is an Associate Professor in the Maternal and Child Health Program in the School of Public Health at the University of Minnesota.

SOCIAL AND EMOTIONAL DEVELOPMENTAL MILESTONES

The Centers for Disease Control and Prevention's (CDC) Learn the Signs—Act Early website provides an interactive opportunity for parents and caregivers to learn about general developmental changes to expect as their child develops in the first 5 years. Some examples of social and emotional developmental milestones from the website include:

By the end of Three Months:

- Begins to develop a social smile;
- Enjoys playing with other people and may cry when playing stops; and
- Imitates some movements and facial expressions.

By the end of One Year:

- Cries when mother or father leaves;
- Enjoys imitating people in his play; and
- Repeats sounds or gestures for attention.

By the end of Two Years:

- Imitates behavior of others, especially adults and older children;
- Demonstrates increasing independence; and
- Begins to show defiant behavior.

By the end of Three Years:

- Can take turns in games;
- Understands concept of "mine" and "his/hers;" and
- Expresses a wide range of emotions.

By the end of Four Years:

- Cooperates with other children;
- Increasingly inventive in fantasy play; and
- Negotiates solutions to conflicts.

By the end of Five Years:

- Wants to please friends;
- Able to distinguish fantasy from reality; and
- Sometimes demanding, sometimes eagerly cooperative.

For more information about how the CDC is helping parents, educators, and caregivers to recognize signs of healthy development of young children and provide care earlier for children with developmental delays, please visit: http://www.cdc.gov/ncbddd/actearly/milestones/index.html

Diagnosing Young Children with Mental Health Concerns

Catherine Wright, MS

If the result of social-emotional screening for an infant or young child is positive (i.e., indicates mental health problems or concerns), the next step is an assessment to determine if the child needs specialized services.

Diagnostic Assessment

An early childhood mental health diagnostic assessment is a formal process conducted by a trained mental health professional that incorporates comprehensive information about the child's developmental history, current functioning (including strengths and vulnerabilities), and family history. It also includes observations of the child interacting with his/her caregivers and with the mental health professional. The purpose of diagnostic assessment is to determine if the child needs specialized services and more specifically, what treatment modalities might be useful for the child and family. Diagnostic assessment helps to inform treatment; it is *not* a mechanism for labeling children. Diagnostic assessment is ongoing, requiring periodic re-evaluation as the child enters different developmental stages and experiences different life events.[1]

DC:0-3R

The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R) was released by the national organization, Zero to Three, in 2005. The *DC:0-3R* manual is used to provide developmentally appropriate diagnostic assessments for children, birth to 4 years, with mental health conditions. The diagnostic categories are research-based and were developed by medical and mental health professionals with expertise in infant and early childhood mental health and developmental conditions.[1,2] The *DC:0-3R* diagnostic categories, based on early childhood development research, are not described in other diagnostic systems.

Key principles and assumptions of the DC:0-3R include:

- The developmental domains for infants are inter-related and require the integration of professional perspectives from mental health, rehabilitation services, medical, and social service professionals.
- Infants and young children develop in the context of relationships, culture, and community. Their relationships with their primary caregivers are paramount to their development. Thus, clinicians must engage the children's primary caregivers as partners in the assessment process. The children's relationships with their primary caregivers, their cultures, and their communities must be incorporated into the diagnostic process.
- Infants and young children are unique and their development, temperament, and other differences affect the way they experience various events.
- The diagnosis of young children is a process that must include information from multiple sources, including all caregivers who engage regularly with the child, and must include observations of the young child in multiple settings.[1]

Minnesota's Promotion of the DC:0-3R

The Minnesota Department of Human Services (DHS), Children's Mental Health Division, in partnership with local communities, the Maternal and Child Health Assurance Unit at DHS, and the Minnesota Department of Health have promoted the use of the *DC:0-3R* by providing free trainings to mental health professionals across the state. Over 700 Minnesota mental health professionals have been trained in the use of the *DC:0-3R*. The DHS Children's Mental Health Division offers ongoing consultation for mental health professionals through a free monthly clinical consultation group staffed by a contracted national *DC:0-3R* trainer. For more information about the *DC:0-3R* trainings offered throughout Minnesota or the *DC:0-3R* monthly clinical consultation group, contact Catherine Wright at catherine.wright@state.mn.us

REFERENCES

1. Zero to Three. Overview: Diagnostic classification of the mental health and developmental disorders of infancy and early childhood: Revised. Unpublished paper, 2006.
2. Zero to Three. Diagnostic classification of mental health and developmental disorders of infancy and early childhood: Revised edition. Washington, DC: Zero to Three Press, 2005.

Catherine Wright, MS, is an Early Childhood Mental Health Program Coordinator at the Minnesota Department of Human Services, Children's Mental Health Division.

Early Childhood Mental Health Systems

Development in Minnesota

Catherine Wright, MS

For the past six years, the Minnesota Department of Human Services (DHS) Children's Mental Health Division (CMHD) has been working with community stakeholders across the state to develop an early childhood (birth to 5 years) mental health system of care. Development of this system requires integration across multiple sectors: mental health, medical, early education, Head Start, early intervention, child welfare, and public health. Development of this system has been informed by parents to ensure that it is comprehensive, flexibly designed, and inclusive of all systems serving young children and their families.

Continuum of Care

The Minnesota statewide early childhood mental health system includes four specific domains in the continuum of care:

- Prevention—services available to all children;
- Early intervention—services for children who demonstrate undiagnosed mental health concerns;
- Intervention—services for children with diagnosable mental health conditions; and
- Intensive intervention—intensive services for children with significant diagnosable mental health conditions.

Prevention. Through a Commonwealth Grant, Assuring Better Child Development (ABCDII), the CMHD partnered with the DHS Maternal and Child Health Assurance Unit to promote the use of standardized mental health screening tools during Child and Teen Check-Ups* conducted in medical clinics. The screening tools assist caregivers and medical professionals in identifying social-emotional concerns in young children. The Maternal and Child Health Assurance Unit was also recently awarded the ABCD III grant from the Commonwealth Fund and the National Academy for State Health Policy (NASHP). This grant will assist medical clinics in connecting with local early intervention services for children with identified mental health and developmental concerns.

Early intervention. In 2006, the Minnesota Department of Education, with support from state and local agency partners, changed the eligibility criteria for Part C of the Individuals with Disabilities Education Act (IDEA) to include 13 early childhood mental health diagnoses listed in the *DC:0-3R* (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition).[1] The new eligibility criteria allow children birth to 2 years with mental health conditions to receive the full early intervention services offered through Part C.[2]

The CMHD also is working closely with the Minnesota Head Start Association to promote the use of the *Incredible Years*[3] curriculum, an evidence-based early intervention for children with potential behavioral concerns.

Intervention. For the past six years, the CMHD, in partnership with the Minnesota Department of Health's Minnesota Children with Special Health Needs (MCSHN) section, has been working with the national organization, Zero to Three, to train and mentor mental health professionals in the use of the *DC:0-3R*, a developmentally appropriate mental health diagnostic tool

**Child and Teen Checkups is Minnesota's name for Early Periodic Screening, Diagnosis and Treatment (EPSDT), which is required by Medicaid.*

Continued on page 12

for children ages birth to 4. Over 500 mental health professionals have been trained in the use of the tool.

In addition to diagnostic assessment training, the CMHD is training mental health professionals in the use of evidence-based mental health treatments for young children. Over 21 clinicians from 13 agencies have been trained in the use of *Parent Child Interaction Therapy,*[4] an evidence-based treatment for young children and their families who have experienced trauma or are exhibiting other mental health disorders.

Intensive interventions. The CMHD has been working closely with Minnesota Health Care Plans and mental health practitioners to provide an array of intensive interventions for young children with significant mental health conditions. These services include mental health targeted case management, day treatment, and therapeutic preschools.

Evaluation

The CMHD recently required all mental health professionals who receive public reimbursement for services to birth to 5-year-olds to use two evaluation instruments: the *Strengths and Difficulties Questionnaire*[6] (an assessment tool for children ages 3 to 5) and the *Early Childhood Services Intensity Instrument*[7] (a functional assessment tool for children ages birth to 5). The State chose to evaluate state-funded mental health services so that families and consumers would have information to better choose from the array of services and providers for their children.[5]

Infrastructure Building

Through the Governor's Mental Health Initiative of 2007, the CMHD has released 3 million dollars in direct service/infrastructure building grants for early childhood mental health systems development across the state. In April 2009, 10 communities were awarded these grants to develop comprehensive services for children, birth to 5 years, employing the four categories of the continuum of care using the state-required evaluation tools.

REFERENCES

1. Zero to Three. Diagnostic classification of mental health and developmental disorders of infancy and early childhood: Revised edition. Washington, DC: Zero to Three Press, 2005.
2. Minnesota Department of Health. Early childhood intervention Part C. Available from: http://www.health.state.mn.us/divs/fh/mcshn/ecippkt.htm
3. More information about the Incredible Years programs is available from: http://www.incredibleyears.com/
4. Eyberg SM, Boggs SR, Algina J. Parent-child interaction therapy: a psychosocial model for the treatment of young children with conduct problem behavior and their families. Psychopharmacol Bull. 1995;31(1):83-91.
5. Minnesota Department of Human Services. Bulletin. DHS requires standardized outcome measures and level of care determinations for children's mental health. April 2009. Available from: http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_144775.pdf
6. Goodman R. The Strengths and Difficulties Questionnaire: a research note. J Child Psychol Psychiatry 1997; 38:581-586.
7. American Academy of Child and Adolescent Psychiatry, Work Group on Community-based Systems of Care. Early Childhood Service Intensity Instrument (ECSII). 2005. Available from: http://www.aacap.org/galleries/PracticeInformation/Information_sheet_ECSII.pdf

Catherine Wright, MS, is an Early Childhood Mental Health Program Coordinator for the Children's Mental Health Division at the Minnesota Department of Human Services.

For more information about early childhood systems development efforts in Minnesota, please contact Catherine Wright at catherine.wright@state.mn.us.

MINNESOTA ASSOCIATION OF CHILDREN'S MENTAL HEALTH:

FROM A PARENT SUPPORT GROUP TO A STATEWIDE ADVOCACY ORGANIZATION

The Minnesota Association for Children's Mental Health (MACMH) was established in 1989 by a small group of parents who shared the experience of raising children with mental health disorders. Today MACMH is a statewide education and advocacy organization. Its mission is "to promote the positive mental health of all infants, children, adolescents, and their families" and is carried out through education, advocacy, and an annual conference. MACMH has published curricula for parents, educators, and other practitioners and offers numerous trainings in Minnesota. Among MACMH's resources are its Guide to Early Childhood Mental Health, mental health factsheets (in English and Spanish), and a newsletter. Its Open-Up magazine is one component of a new arts-based community outreach initiative that showcases the work of young people through essays, poems, and visual arts to impart powerful messages about mental health.

According to MACMH, its annual conference is the largest of its kind in the nation, offering parents, caregivers, and professionals access to more than 75 workshops of varying technical levels and nationally renowned keynote speakers. The 2010 conference will take place April 25-27 at the Duluth Entertainment Convention Center.

For more information about MACMH go to: http://www.macmh.org/index.php

Evidence-based Practices

in Early Childhood Mental Health

Glenace E. Edwall, PsyD, PhD, LP, MPP

Evidence-based practice (EBP) in mental health is a relatively new phenomenon, with virtually no citations prior to 1995 in the published literature. However, only a decade later, PsycINFO contained 271 references to EBPs for children and adults. There are many recent review articles and books about the emerging science of determining what works, for whom, and under what conditions.

What Is the Meaning of EBP?

The American Psychological Association (APA) has provided leadership in defining and promulgating EBPs for children's mental health. In a 2008 task force report, APA noted that the term EBP has come to connote:

- A broader focus than evidence-based treatment, which is limited to prevention or intervention programs for which there is a strong scientific base;
- The quality, robustness, and/or scientific evidence about prevention, treatment, access, engagement, and retention of targeted client populations;
- Incorporation of client characteristics as well as clinical expertise; and
- A coherent body of scientific knowledge relevant to a range of service and clinician practices, which allows for prediction of the impact of interventions.[1]

EBPs: Questions and Issues

Particularly as applied to early childhood mental health services, a number of challenging questions are often raised about EBPs.

- ***What "evidence" is required to establish an EBP?*** Early EBPs emphasized what is now referred to as a "gold standard" of evidence, including double-blind, randomized trials with control groups, using competing interventions, manualized practices, studies by more than one group of researchers, and statistically and clinically significant differences in outcomes favoring the practice in question.[2] If we relied solely on this standard, there would be very little "evidence" for effective practice. More recent approaches to EBPs have included somewhat broader research criteria. For example, the National Registry of Evidence-based Practices and Programs assigns ratings from 1 to 4 on specific criteria: reliability and validity of measures, intervention fidelity, missing data and attrition, potential confounding variables, and appropriateness of analysis.[3] The database that Minnesota is using to train providers, developed from the work of Dr. Bruce Chorpita (University of California–Los Angeles), also assigns a rating based on the quality of research underlying a specific practice, as well as notes the demographic and diagnostic application of the practice, to the extent that this information is specified in the practice's research reports. Evidence that is still needed in the early childhood domain is that from longitudinal interventions.
- ***Do EBPs privilege some values over others?*** EBPs are unapologetically rooted in the tradition of scientific evidence derived from experimental research. As the field has evolved, there has been increasing attention to contextual factors related to evidence, including the importance of individualized care, strengths- and family-based care, and cultural competency.
- ***Do EBPs reinforce the "medical model" of mental health?*** EBPs are certainly rooted in health care, and particularly in evidence-based medicine. Compared with EBPs for adult care, EBPs for children generally have a more developmental and preventive focus.

Continued on page 14

- ***Do EBPs work across different settings, e.g., clinics, home visits, preschools?*** The range of settings in which the effectiveness of EBPs has been demonstrated is constrained by the published literature, but cross-setting generalizability can sometimes be extrapolated or tested in the next iteration of a specific practice.
- ***How do EBPs relate to an emphasis on outcome measurement?*** The use of EBPs is dependent upon, not a replacement for, clear measurement of outcomes. EBPs are generally defined by efficacy—the ability to produce a desired effect in a controlled context; but effectiveness—the degree to which the intervention produces the desired effect in real-world, uncontrolled settings—demands rigorous measurement.
- ***How do EBPs relate to family preferences and choice?*** Family preference and choice have been empirically demonstrated to have a clear role in the engagement phase of mental health treatment. As more research establishes a wider range of alternatives for the treatment of common children's mental health problems, more choice among effective treatment modalities is opened for families.
- ***Are EBPs used to restrict access to services?*** This has been a common fear about EBPs, with limited examples, primarily in adult services. More common practice among states is to use EBPs as part of quality improvement activities and provider training. This has been the case for the Children's Mental Health Division at the Minnesota Department of Human Services (DHS).
- ***What are the ethical considerations in implementing EBPs?*** Assuring access to the highest quality of care for all children, training, and adequate supervision are all hurdles that states must plan for in implementing EBPs.

EBPs: Why and Why Now?

The Children's Mental Health Division of DHS is frequently asked why so much attention is given to implementing EBPs for intervention in children's mental health problems. The top answers are:

- EBPs provide the best opportunity to maximize the effectiveness of interventions, including providing a clear focus on outcomes.
- EBPs clarify clinicians' case conceptualizations, particularly those emanating from theoretical perspectives.
- Adoption of EBPs creates the possibility of continuity and consistency of care across providers.
- EBPs create a common language for understanding interventions, much like prior work on screening *(e.g., ASQ:SE)* and diagnosis *(DC:0-3R)*.
- EBPs create the basis for training in core elements of interventions, thus increasing the effectiveness of all interventions for children.
- Effectiveness and quality are linked to better outcomes with lower resource use.
- Rapid return to a typical developmental trajectory is particularly crucial for young children to lessen the possibility of more complex problems or acquired co-morbid conditions.
- Pragmatically, EBP implementation is increasingly a requirement of federal and private grant-making.
- The publication explosion around EBPs is making it ethically indefensible not to offer children and families the best care available. Just as it once seemed logical not to screen for problems in the absence of treatment resources (but no longer does), it is also no longer arguable that any service is as good as any other. The *right* care has become the *right* thing to do.

Evidence-based practices make it ethically indefensible NOT to offer children and families the best care available...The right care has become the right thing to do.

REFERENCES

1. American Psychological Association Task Force on Evidence-Based Practice for Children and Adolescents. Disseminating evidence-based practice for children and adolescents: a systems approach to enhancing care. Washington, DC: American Psychological Association, 2008. Available from: http://www.apa.org/pi/cyf/evidencerpt.pdf
2. Chambless D, Hollon S. Defining empirically supportable therapies. J Consult Clin Psychol 1998; 66:7-18.
3. National Registry of Evidence-Based Practices and Programs. NREPP Review Criteria, 2007. Available from: http://nrepp.samhsa.gov/review-quality.asp.

Glenace E. Edwall, PsyD, PhD, LP, MPP, is the Director of the Children's Mental Health Division at the Minnesota Department of Human Services.

Early Childhood Family Education (ECFE):

A Mental Health Promotion Program for Young Children and Families

Lois Engstrom

"*I don't have any friends.*" "*Nobody likes me.*" These words from a 4-year-old bring into focus the importance of addressing social-emotional development during a child's early years. Until recently, this domain of early development had received less attention compared to motor, cognitive, and language development. However, social-emotional competence is equally important and essential to children's well-being and success in school and in later life.

Importance of Early Relationships

In the now classic report from the Institute of Medicine, *From Neurons to Neighborhoods; the Science of Early Childhood Development,*[1] the authors highlight the importance of early life experiences and the highly interactive nature of genetics and environment. Early relationships are critical to the development of the infant brain and in turn, to the unfolding patterns of human development, including social-emotional competence. Parents, other caregivers, and teachers need to provide the environments and interactions that enable children to learn to trust others, gain self-control, demonstrate age-appropriate levels of independence, and acquire the ability to take initiative and assert themselves in socially acceptable ways.

Parents have a profound influence on the early development of their children. Nearly all parents want to do the best they can for their children at home and select high quality out-of-home care environments. Early childhood teachers and specialists in a variety of settings are trained to provide the most effective learning environments for young children as well as support for parents.

Nearly all parents want to do the best they can for their children at home and select high quality out-of-home care environments. Many parents seek information and support in this endeavor

Minnesota Legislation Supports ECFE

Minnesota is fortunate to have statutory provisions making Early Childhood Family Education (ECFE) available to all parents to support them as their children go through various stages of development from birth to kindergarten enrollment. ECFE began in 1974 with six state-funded pilot programs administered by the Minnesota Council on Quality Education, which coordinated a variety of research and development strategies funded by the legislature. The number of pilots expanded gradually to 34 in 1983 when the Minnesota Legislature began to make the transition from grant-funded pilots to a foundation aid formula and statewide implementation through Community Education in public school districts. Now ECFE is offered essentially by all school districts, either independently or in cooperation with other districts.

In accordance with Minnesota statute 124D.13, all programs must provide:

- Education to parents on the physical, mental and emotional development of their children and enhancing the skills of parents* in providing for their children's learning and development;
- Structured learning activities requiring interaction between children and their parents;
- Structured learning activities for children that promote children's development and positive interaction with peers, which are held while parents attend parent education classes;
- Information on related community resources;

**The phrase "or relatives" was added to the statute recently to include those who play a major parenting role in the lives of the children involved.*

Continued on page 16

Early Childhood Family Education from page 15

- Information, materials, and activities that support the safety of children, including prevention of child abuse and neglect; and
- A community outreach plan to ensure participation by families who reflect the racial, cultural, and economic diversity of the school district.

ECFE Programs Are Tailored to Parents' Needs

Parents and children attend ECFE programs together. Programs are usually offered for a sliding scale fee or free of charge. In addition to the program requirements above, school districts vary in the specific programs that are offered as they adapt programs to the changing structure and needs of families in their communities. For example, some ECFE programs offer:

- Daytime, evening, and Saturday classes to accommodate parents' schedules;
- Family literacy programs;
- Classes for specific affinity groups like fathers, single parents, and parents of infants;
- Home visits;
- Classes at hospitals for parents of newborns; and
- Parenting education for court-ordered parents.

Within a given community, ECFE professionals collaborate and coordinate their efforts with other early education programs like child care, crisis nurseries, Head Start, early childhood special education, interagency early intervention services, and nurse home visiting.

Benefits of ECFE

Not only do parents and their children benefit directly from ECFE, but society benefits too, because healthy and supported families are better able to develop nurturing relationships with their children that contribute to their social and emotional competence. In this way, ECFE promotes positive mental health for children. One of the greatest testimonials to the value of ECFE is that so many parents report ECFE has helped them to understand and more effectively meet their children's needs, while simultaneously providing them with a strong source of support and connectedness with other parents and families who often become long-time friends.

For more information about ECFE programs in your area, see www.ecfe.info/what_is_ecfe.html

REFERENCE

1 Shankoff J, Phillips D. (Eds.) and the National Research Council and Institute of Medicine. From neurons to neighborhoods: the science of early childhood development. Washington, D.C.: National Academy Press, 2000.

Lois Engstrom is the Executive Director of the Minnesota Association for Family and Early Education. She was statewide coordinator of ECFE at the Minnesota Department of Education from 1983-2003.

CULTURAL ADAPTATION OF A PARENT EDUCATION PROGRAM FOR SOMALI WOMEN

Nadifa Osman

I am a Somali immigrant to the U.S. and have been living in the Twin Cities for several years. I became increasingly aware of the social isolation of many other Somali women who had more recently immigrated to Minnesota. Many of these women were parenting children, some of whom were not their own because their parents had been killed or lost in their flight from the war in Somalia. Many of these women had lost their partners and their extended families. They appeared depressed, although the Somali culture does not really recognize depression as an illness for which medical help is available. I was concerned about the health of these women and how their depressed mood was affecting their ability to be good parents.

In 2003, I brought six of these mothers together and started teaching them parenting skills using a curriculum developed by Family Services Inc. and Children's Home Society. These agencies wanted me to modify the curriculum so it would fit the cultural beliefs of East Africans. I struggled a lot because many of the parents believed that I was introducing Western culture and parenting practices and encouraging them to neglect their own culture and parenting style. I searched for information about how Islam said children were to be raised. I found a book called, *Meeting the Challenge of Parenting in the West: An Islamic Perspective*, written by a child psychologist who raised four of her children in the western world while adhering to her Muslim faith. What surprised me was that this book contained the same information as the Family Services parenting curriculum. The major difference was it used citations from the Qura'n and sayings from Prophet Mohamed. I started using this book as a teaching tool and reference. It created a drastic change of attitude in these Muslim mothers and gave them great reassurance that the parenting practices we were talking about totally fit with their Islamic faith.

Meeting as a group of women with a shared trauma experience who also wanted to be good parents, they found support and friendship from each other, which seemed to relieve some of their depressive symptoms. The group quickly mushroomed into over 30 women and has continued to meet for several years. I have had requests from other Somali women throughout the Twin Cities to start a similar group for them.

It taught me the importance of honoring cultural beliefs and practices and providing support to suffering women who desperately wanted to be good mothers and protect their children from harm.

REFERENCE

Beshir E, Beshi MR. Meeting the challenge of parenting in the west: An Islamic perspective. Beltsville, MD: Amana Publications, 2000.

Nadifa Osman is a Minneapolis resident and Executive Director of a non-profit, Women of Africa Resource and Development Association (WARDA).

Clinical and Public Health Perspectives on

Mental Health Disparities in Early Childhood

Andrea Aga

"Health disparities" refers to the greater incidence, prevalence, mortality, and burden of disease among specific population groups—based on factors such as race, ethnicity, socioeconomic status, disability, etc. In the U.S., health disparities begin at very young ages (often *in utero*) and persist throughout the life course. The disproportionate exposure of racial/ethnic minorities and low-income families to high-risk, resource-poor environments may explain the disparities in social-emotional problems among these young children, according to Dr. Charles Oberg, a pediatrician and an Associate Professor in the Maternal and Child Health Program in the School of Public Health at the University of Minnesota. There is also an achievement gap between children from at-risk backgrounds and their more advantaged peers—a gap that is apparent even among young children[1,2] and likely associated with disparate social-emotional development.

Environmental Exposures

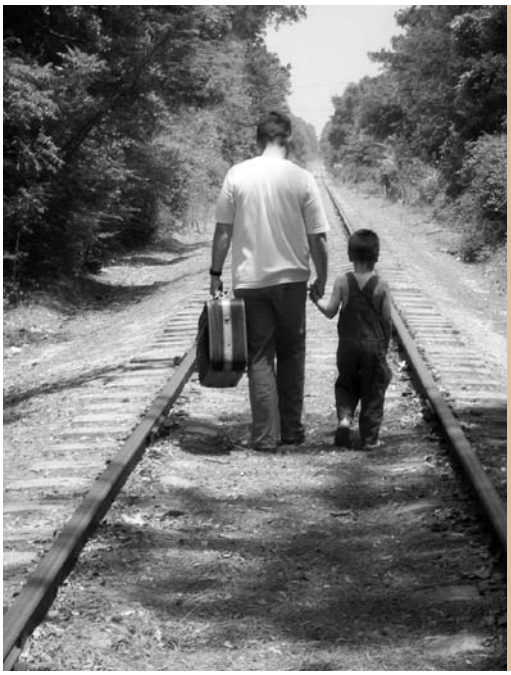
Racial/ethnic minority children and those from low-income families have disproportionate residential exposure to old housing, industrial waste, landfills, and environmental pollutants, like lead.[3] Lead exposure comes primarily from lead-based paint; toddlers ingest paint chips and dust through normal hand and mouth activity. Lead is also in the soil of high-traffic and industrial areas, thus affecting the play areas of children who live in such areas. Early exposure to lead is associated with aggressive behavior and poor intelligence testing. Lead, mercury, dioxins, polychlorinated biphenyl compounds (PCBs), and other toxins also cross the placenta, affecting fetal neural development.[4,5] The mechanisms by which specific deficits develop are not well understood.[4,5] Among the many aims of the National Children's Study (NCS) is to understand how environmental exposures may affect neurodevelopment, from fetal life throughout young adulthood. Dr. Oberg is a co-investigator and Dr. Wendy Hellerstedt, Director of the Center for Leadership Education in Maternal and Child Public Health, is the co-Principal Investigator of the Ramsey Location for the NCS (www.nationalchildrensstudy.gov).

Family Economic Stress

When the families of young children undergo persistent financial strain, they are faced with a number of stressors in their daily lives—food insecurity, unemployment, homelessness, frequent moves, and unsafe neighborhoods. This kind of stress makes it difficult for parents and other caregivers to develop nurturing, protective, and consistent relationships with their infants and young children. Such relationships are essential for the child's development of secure attachment, emotional regulation, and other developmental milestones.

Clinical Care for Stressed Families

Disparities persist beyond children's residential environment. In many clinical settings, there are variations in the services provided for young children who experience emotional and social developmental delays or have mental health problems. While such problems should be recognized during the screening portion of well-child exams—which includes anticipatory guidance and listening to a family's concerns—there are differences in the quality of care and the amount of time devoted to such screening.



To address this variability and ensure that children receive high quality care, Dr. Oberg suggests "improved consistency in training, more readily available assessments, and having referrals in place to help address the needs that are identified."

Importance of provider training. While the type of training providers receive has changed over time, more must be done to ensure that providers are able to competently address the social and emotional health needs of children. Dr. Oberg supports the idea of a medical home, an approach that grew from efforts to provide continuous and comprehensive care for children with special health care needs. This model allows the provider to link with the family, school, and community to coordinate care through multiple systems: health, education, and social services. Clinicians need more training and education to become familiar with the medical home model and skilled in implementing it.

Continued on page 18

Stigma and Lack of Awareness of Resources

Families may not be aware that their young children have mental health problems or they may not be aware that resources exist to address them. Consequently, Dr. Oberg emphasizes the importance of early childhood education programs because they are encouraged to evaluate and promote a child's emotional and mental health. High-quality programs also provide an environment that is developmentally appropriate and emotionally safe, and support coordination between social and health care services.

Some families, and some cultures, may stigmatize mental health or be reluctant to seek services for other reasons. While stigma exists, Dr. Oberg believes it has become less of a barrier for accessing mental health care for children. "What I've noticed when there is an issue facing the family in regards to the social and emotional health of their infant, toddler, or child," he said, "is that they are reaching out, looking for services. I think that speaks to an evolutionary change within our society." Due to this shift, Dr. Oberg also believes mental health is going to be a major focus for the next several decades in the medical, public health, and social service fields.

"What I've noticed when there is an issue facing the family in regards to the social and emotional health of their infant, toddler, or child, is that they are reaching out, looking for services. I think that speaks to an evolutionary change within our society." - Dr. Charles Oberg

Role of Public Health Practitioners

Dr. Oberg believes public health practitioners can be instrumental in addressing mental health disparities. Child social and emotional health and development should be part of a public health graduate curriculum, he suggests. He points to two certificate programs available at the University of Minnesota—one in infant and early childhood mental health and another in early childhood policy (see links, end of article). These certificates blend disciplines and enhance the public health curriculum. On a broader level, Dr. Oberg states that policy development is necessary to support the economic well-being of families, given the higher risk for mental health problems among children in financially stressed families.

Dr. Oberg emphasizes that children, including those from birth to 5 years, need good physical health *and* good social and emotional health. Children must have adequate nutrition, quality housing, parents with livable wages to eliminate financial stresses, and resources to address violence in the home. According to Dr. Oberg, "intervention early on really does pay off substantially as children enter into middle childhood, adolescence and young adulthood."

For more information about the afore mentioned certificate programs offered at the University of Minnesota, please visit:

- Infant and Early Childhood Mental Health Certificate at the Center for Early Education and Development Program, www.cehd.umn.edu/CEED/profdev/certificateprograms/IECMH/default.html. Also see page 35.
- Early Childhood Policy Certificate Program in the College of Education and Human Development, www.cehd.umn.edu/students/Certificates/ECPolicy.html

REFERENCES

1. Hart B, Risley T. The early catastrophe: the 30 million word gap by 3. Am Educator 2003; 27(1);4-9.
2. Halle T, Forry N, Hair E, et al. Disparities in early learning and development: lessons from the Early Childhood Longitudinal Study – Birth Cohort (ECLS-B). Available from: www.childtrends.org/Files//Child_Trends-2009_07_10_FR_DisparitiesEL.pdf.
3. Powell DL, Stewart V. Children. The unwitting target of environmental injustices. Pediatr Clin North Am 2001; 48(5):1291-305.
4. Schantz SL, Widholm JJ, Rice DC. Effects of PCB exposure on neuropsychological function in children. Environ Health Perspect 2003; 111(3):359-76. Available from: www.ehponline.org/members/2003/5461/5461.html
5. Patandin S, Lanting CI, Mulder PG, et al. Effects of environmental exposure to polychlorinated biphenyls and dioxins on cognitive abilities in Dutch children at 42 months of age. J Pediatr 1999;134(1):33-41.

Andrea Aga is an MPH student in the Maternal and Child Health Program at the University of Minnesota.

EARLY CHILDHOOD LONGITUDINAL STUDY: DISPARITIES IN EARLY CHILD DEVELOPMENT

In June 2009, *Child Trends* published an analysis about multiple potential risk factors for developmental disparities at 9 and 24 months of age. Data were from a nationally representative sample of infants born in 2001, the Early Childhood Longitudinal Study. The authors (Halle et al.) examined three domains of development: cognitive, general health, and social-emotional.

Some of the key findings of this report were:

- Disparities in cognitive, social, behavioral, and health outcomes by family income were evident at 9 months and were even greater at 24 months of age.
- Infants and toddlers from certain backgrounds (i.e., racial/ethnic minority groups, whose home language was not English, and/or who had mothers with low maternal education) scored lower on cognitive assessments, had poorer behavior ratings and were less likely to be in excellent or very good health than children not from such backgrounds.
- The more sociodemographic risk factors a child had (e.g., low-income family, mother with low education), the wider the disparities across outcomes for 9- and 24- month-olds.

The sociodemographic risks examined in this study affect a significant number of infants and toddlers in the US. For example, nearly half of all infants and toddlers—approximately 1.5 million children—live in families with incomes below 200% of poverty.

The authors drew several policy implications from their analyses:

1. ***Start Early.*** Meaningful differences in outcomes were detected as early as 9 and 24 months. They recommended high quality, comprehensive and continuous interventions for children ages 0 to 3, as well as ages 3 to 5.
2. ***Target Low-income Children.*** Low income was the most prevalent risk factor in the study.
3. ***Engage and Support Parents.*** Low maternal education was a prevalent risk factor. The authors suggested interventions that include parental education about early childhood development and those that support parental educational attainment and/or income self-sufficiency.
4. ***Improve the Quality of Early Care Settings.*** Most infants and toddlers (especially those from low-income families) are cared for in home-based settings. High-quality early care and education may moderate the effects of stressful residential exposures and may promote safe, supportive and stimulating environments for young children.

The full report is available at: www.childtrends.org/Files//Child_Trends-2009_07_10_FR_DisparitiesEL.pdf.

Family Home Visiting

A Public Health Program to Promote Healthy Social-Emotional Development

Sharon Hesseltine, BSW
Jill E. Simon, MSW, LICSW, IMH-E® (IV)

Minnesota family home visiting programs focus on preventing children's mental health problems by offering support directly to families in their homes.[1] Public health nurses or trained home visitors support parents of infants and toddlers by providing information and guidance about child health and development, promoting parenting skills, and enhancing parents' ability to engage in positive interactions with their children. During these visits, potential threats to the emotional health of the child, including a parent's mental health problems, parent addictions, or family violence are identified and referrals to needed resources are made.

Building a Supportive Relationship

Essential to the effectiveness of ongoing home visits is having the family experience a supportive and continuing relationship with a visitor. This relationship promotes the parent's capacity to care for the child in a manner that fosters healthy attachment. Research shows that supportive relationships in the parent's life have a significant and long-term positive influence on the parent-child relationship. It is well-documented that an infant's healthy attachment is a major contributing factor in optimal social, emotional, and cognitive development of the child.[2]

To enhance the capacity of family home visitors in the work of relationship-building, the Minnesota Department of Health (MDH) provides training, technical assistance, and consultation.

Training

A new family home visiting training curriculum, "Promoting Relationships with Relationships," is available to public health home visitors in Minnesota. This training addresses infant mental health, parent-child attachment, and culturally responsive practice. To emphasize the ongoing development of relationship-building skills and knowledge, the course material is presented through a series of home visiting case scenarios. This method allows participants the opportunity to learn concepts by applying them to a home visiting situation and gain insight through discussion with peers and trainers. In each scenario, participants are encouraged to focus on how to use the visitor-parent relationship as the primary vehicle to effect change. Future training development will continue to promote the fundamental skills and theoretical underpinnings of evidence-based home visiting practice and its relationship to infant mental health.

One of the tools that home visitors use is the *Parent-Child Interaction (PCI) Feeding and Teaching Scales,*[3] which assess the quality of parent-child interaction and communication behaviors. Results of this assessment can be used by home visitors to support parents' learning about how to respond to their infants' cues, which is a critical component of sensitive caregiving. Home visitors also receive training in motivational interviewing,[4] which is a collaborative, person-centered discussion to elicit and strengthen parents' motivation for making healthy changes.

Reflective Practice

An essential component of most evidence-based home visiting models is the use of reflective practice, which involves "stepping back" to consider the meaning of one's professional and personal responses to relationship interactions. The home visitor steps back to ponder her own reactions, wonder about the parent's perspective, and reflect on how she might best help the parent discover her or his own solutions. Likewise, the home visitor helps the parent think about his or her thoughts and feelings, consider the child's experience, and identify solutions that encompass both perspectives. Essentially there is a parallel process; that is, the home visitor relates to the parent in a healthy respectful manner, which builds the parent's capacity to develop a healthy relationship with his or her child. The goal of reflective practice is to gain a better understanding of relationships—between the parent and child, as well as between the home visitor and parent—so that all relationships support the healthy emotional development of the child.

MDH offers a reflective practice consultant to local public health departments to support and strengthen home visitors' skills in using a reflective approach with families. The consultant facilitates reflective practice case conferences and provides mentoring and reflective practice groups for supervisors. Reflective supervision contributes to an understanding of home visitor boundaries and roles and clarifies goals and areas of intervention.

Continued on page 27

Follow Along Program: An Early Childhood Intervention System at the Minnesota Department of Health

Andrea Mayfield

For infants and young children with developmental delays, early intervention is important to improve health outcomes and address challenging behaviors in the school and home environments. A major challenge in providing early intervention services is the ability to accurately identify infants and young children with social, emotional, and other developmental delays early in childhood. The Minnesota Department of Health (MDH) Follow Along Program (FAP) provides periodic monitoring and screening to help families and health care professionals determine if infants are meeting expected developmental milestones.

Origins of the FAP

Lola Jahnke, a Public Health Social Work Specialist with the FAP, has seen the program grow from its infancy to statewide implementation. In the 1980s, Jahnke and other service providers noticed that children with developmental delays were not being identified until they reached school age. She explains, "at that point in time, there wasn't much around for kids from birth to five." A group of providers collaborated to find a "low-cost option" that would identify and monitor the social and emotional development of young children. The FAP grew out of these meetings.

From Screening and Monitoring to Referral

Families with children in the Program receive the *Ages and Stages Questionnaire (ASQ)* and *ASQ:SE* (social-emotional) when the child reaches 4, 8, 12, 16, 20, 24, 30, and 36 months of age. After the family completes the questionnaires, they are scored by public health staff at the local county agency. Families with children who are developmentally on-track are sent a letter informing them of the survey results along with an activity sheet with age-appropriate activities to practice with their children. When there are concerns about a child's developmental progress, the public health nurse contacts the child's family to ensure they responded to the questions appropriately. If there are remaining concerns, the nurse discusses options for follow-up, including referral to a primary care physician, Part C of IDEA (Individuals with Disabilities Education Act), an early intervention program for infants and toddlers, or other health and social service programs. This process ensures that parents receive support in learning about normal child development and children with developmental delays are identified and connected with intervention services early.

Funding for FAP

While FAP at the state level receives federal funding, local county agencies throughout Minnesota support the cost of their FAPs through a variety of sources. As these programs have "no direct line of funding through the MDH…they are given lots of flexibility in terms of how they run the program," explains Jahnke. As a result, counties use different recruitment strategies and eligibility criteria. Some provide the program to all newborns, while others only offer the program to at-risk children. In counties that offer the program to all children, administrators obtain birth certificate information from the local public health department and invite parents of all newborns to participate. Other referrals come from home visiting programs, hospitals, physicians, and word of mouth.

Enrollment in FAP varies throughout the state. While 12% of children birth to 3 years participated in FAP statewide in 2008, enrollment ranged from 4% in the metro area to 29% in southwestern Minnesota where the program started first.

Next Step after FAP

When a child reaches 36 months, participating families receive information about the next step: Early Childhood Screening. The state of Minnesota mandates that all children receive one screening (including social and emotional) prior to kindergarten. Results from these screening tests are reported to the Minnesota Department of Education (MDE) and help determine if children are in need of special education. Together, these programs facilitate the timely identification of children with developmental delays, promote early access to intervention services when needed, and help to ensure that families are connected with a health care provider as children enter the school-age years.

For more information about the Follow Along Program, please visit: http://www.health.state.mn.us/divs/fh/mcshn/fap.htm

Andrea Mayfield is an MPH student in the Maternal and Child Health Program at the University of Minnesota.

Part C IDEA, Early Intervention Services:

Serving Children Under 3 Years with Mental Health Concerns

Karen Adamson, RN, MPH

While all states provide early childhood intervention services for children under 3 years of age who are experiencing developmental delays, screening and services for social-emotional delays have lagged behind services for other developmental delays in many states.[1] In Hennepin County, Minnesota, staff provide developmental and social-emotional screening for referred children under age 3. These children are referred from families, pediatric providers, hospitals, and other community sources when a delay is suspected. Screening is done in the home using standardized tools by public health nurses and child development specialists.

In 2008, Hennepin County early childhood staff administered nearly 500 mental health screens using the *Ages and Stages Questionnaire: Social Emotional (ASQ:SE)*.[2] In this sample of children with suspected delays, 17% of the infants under 1 year scored in the "concerns" area and 40% of 1 to 3-year olds, had scores in the "concerns" range.[3] In Minneapolis, all children under age 3 with scores indicating mental health concerns are referred to IDEA Part C, Part C of the Individuals with Disabilities Education Act (IDEA) Early Intervention Services through the Minneapolis School District.

What is IDEA and Part C?

IDEA Part C is a federal program that assists states in providing statewide early intervention services for children, birth to 3 years, with disabilities.[4] Established in 1987 and reauthorized in 2004, all states participate in the program, although there is considerable variation in how developmental delay is defined and how many children are served. Services must be provided for those who are experiencing developmental delays and for those who have a diagnosed mental or physical condition that has a high probability of resulting in a developmental delay. States may choose to serve children "at risk" of experiencing a substantial developmental delay, but currently, only seven states and one territory include those "at risk" of developmental delay.[1]

Interagency Coordination

Part C legislation requires coordination among education, health, and social service agencies in a state, with one agency designated as the lead. In Minnesota, education is the lead, and Interagency Early Intervention Committees (IEIC) have been formed throughout the state to enact this coordination function. School districts are required to provide early intervention services for eligible children in their districts. Because the needs of very young children are frequently complex and not directly observable in a public K–12 system, public health and social services are important partners with education in finding young children experiencing developmental delays. Screening is just the beginning. Part C Early Intervention Services require a full evaluation for all children whose screens indicate developmental delays, and services are provided at no cost to families through the school district.

Early Intervention Services for Social-Emotional Delays

Determination of service need is based on an education model. As we screen young children for mental health concerns, we find that there are some children who do not meet the eligibility criteria for educational intervention, but have very significant needs as evidenced by their interactions and behavior. It is for these children that Hennepin County social workers try to provide additional in-home services or referrals to early childhood mental health professionals for therapeutic intervention. These services are provided through county funds or third-party billing.

Services for Abused and Neglected Children

The Child Abuse Prevention and Treatment Act (CAPTA)[5] mandates social-emotional screening and, when warranted, referral to Part C Early Intervention services. In 2008, child welfare staff in Hennepin County administered mental health screens to all children under age 5 who had been in foster care for at least 30 days. Many of these children have significant mental health conditions and require therapeutic intervention in addition to services through the local school district. Nationally, one-third of children ages 2 to 5 in child welfare need mental health services and related interventions.[6]

As we improve our ability to screen more young children in Hennepin County, Minnesota and other states, we realize that we need multiple resources to meet the mental health needs of very young children. In addition, there is a need to assist agencies

Continued on page 23

Minnesota Head Start:

Addressing Mental Health Needs Early

Gayle L. Kelly, MS

When a young child has a fever, you call the doctor. Who do you call when a baby is difficult to console and cries incessantly; or a young child expresses extreme anger and rage; or a preschooler consistently bites and hits other children? In 2004, Minnesota Head Start staff and parents asked these questions as part of a statewide initiative to find better ways to support the social and emotional well-being of young children and their families. Increased awareness of the frequency that children in Head Start were showing challenging behaviors led to an initiative to build an improved system of mental health promotion, prevention, and intervention services within Early Head Start and Head Start programs (collectively called Head Start).

Head Start Goals

Echoing the Zero to Three definition of infant mental health, Head Start's goals are to ensure that all young children can form strong attachments with their caregivers, regulate their emotions, and reach out and explore their environment to learn.[1] These goals underlie all Head Start efforts to provide early learning experiences for young children.

Federal Requirements for Meeting Social-Emotional Needs

The federal Head Start Performance Standards require programs to develop systems for screening, identifying, and treating children with emotional difficulties. They also require Head Start to contract with mental health professionals to offer consultation services for enrolled children with social or emotional problems. Mental health consultants can provide a range of services including classroom observations, in-depth assessments of children, direct therapeutic services, training and/or support for staff, and meetings with parents.

The 2008 federal Program Information Report demonstrated that Minnesota Head Start staff sought consultation with mental health professionals related to the mental health problems of more than 2,100 enrolled children (or 13% of Minnesota's Head Start enrollment).[2] In-house professionals served many additional children and families. The number of children in Head Start with mental health concerns has grown dramatically in the past 10 years.

Addressing Parent Education Needs

Parents look to Head Start to understand their children's social and emotional development, and parent education is a critical component of Head Start's family development services. The *Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)*[3] has been adopted by every Head Start program in Minnesota to screen children and help initiate a dialogue with parents about their child's development. *ASQ:SE* is completed by parents within the first 45 days of their children entering Head Start, and the results are reviewed with every parent. Parents whose children have a positive screening result can request further assessment, and all parents have a variety of options for further discussion with staff specialists or mental health professionals.

New parent education offerings like the *Incredible Years* Parenting Program (see page 26) are being offered in partnerships between Head Start and community mental health organizations throughout Minnesota.

Mental Health Consultation

In 2004, Minnesota Head Start programs faced considerable challenges in finding qualified mental health consultants with early childhood expertise. A partnership between the Minnesota Head Start Association and the Minnesota Department of Human Services (DHS), Division of Children's Mental Health, has contributed to significant progress in improving mental health supports for young children.

Building capacity through training. In 2004, Head Start adopted a "grow your own" approach by partnering with mental health professionals. The Head Start program identified community mental health professionals who lacked training and experience serving young children, but were motivated and willing to acquire additional competencies. The DHS Division of Children's Mental Health began offering regional training grounded in neurobehavioral scientific research and designed to develop trainee competencies in using state-of-the-art methods for screening, assessment, and intervention with children under the age of 5. Head Start programs in many communities provided financial support to help their mental health partners participate in this training. They also made their classrooms available as laboratories to help ground these professionals in the language of early childhood development.

Referral for diagnostic assessment. Prior to 2004, Minnesota Head Start programs referred children with mental health concerns almost exclusively to their local educational agency for evaluation by Early Childhood Special Education (ECSE) (or for a child under 3 years, Part C Early Intervention). Very few children were given a diagnosis related to their social-emotional delay or disability and hence, were not eligible for ECSE or Part C services. Today, more programs have access to mental health professionals who have been trained in developmentally appropriate mental health assessment techniques such as *DC:0-3R* and referrals are often made concurrently to community mental health providers and their local ECSE or Part C team. Head Start programs indicate they now serve many children with mental health problems who are waiting for evaluation by their local Part C or ECSE team or have not qualified for those education services.

Changing role of mental health consultation. Increasingly, Head Start programs are partnering with community mental health organizations with expertise in early childhood, thereby bringing assessment and treatment services into Head Start settings. Today, integrated service approaches are occurring with dramatic positive results for children and families. Examples of the evolving role of mental health consultants in Head Start include:

- In the Duluth Head Start programs, mental health consultants conduct child observations, work closely with parents, and work closely with classroom staff to develop individualized strategies for all children showing challenging behaviors. Reflective consultation is used to help staff recognize the difficulty in caring for children with social-emotional issues.
- Through the work of its consulting psychologist, Parents in Community Action (PICA), Inc., the Head Start provider in Hennepin County, has developed a collaborative partnership with Family and Children's Services to provide on-site play therapy for identified children. PICA's referral-to-follow up ratio is nearly 100%.

The Minnesota Head Start community is redefining the roles of mental health consultants as an invaluable resource for the well-being of children and families, as well as staff. The first priority in comprehensive school readiness must be early learning policies and funding streams that ensure services to promote the social and emotional well-being of children and their caregivers.

REFERENCES

1. Task Force on Infant Mental Health. Definition of infant mental health. Arlington, VA: Zero to Three, 2002. Available from: www.zerotothree.org.
2. Kuklinski W. Data from the 2008 Federal Head Start Program Information Report for Minnesota. St. Paul, MN: Minnesota Department of Education.
3. Squires J, Bricker D, Twombly E. Ages and stages questionnaires: social-emotional (ASQ:SE): a parent-completed, child-monitoring system for social-emotional behaviors. Baltimore: Brookes Publishing, 2009.

Gayle L. Kelly, MS, is Executive Director of the Minnesota Head Start Association, Inc.

continued from page 21
Part C IDEA, Early Intervention Services

that work with young children on a daily basis, such as preschools and child care centers, to employ qualified professionals who are skilled in early childhood services.

REFERENCES

1. Cooper J, Vick J. Promoting social-emotional wellbeing in early intervention services. A fifty-state view. New York: National Center for Children in Poverty, 2009. Available from: http://www.nccp.org/publications/pdf/text_885.pdf
2. Squires J, Bricker D, Twombly MS, Heo K. Identification of social- emotional problems in young children using a parent completed tool. *Early Child Res Q* 2001;16(4):405-419.
3. Hennepin County Human Services and Public Health. 2008 Annual Report: Early Childhood Public Health. Internal publication, available upon request.
4. U.S. Department of Education. Individuals with Disabilities Education Act. Available from: http://idea.ed.gov/
5. Cutler C, Ward H, Yoon SY, et al. Children at risk in the child welfare system: collaborations to promote school readiness. University of Southern Maine: Muskie School of Public Service, April 2009. Available from: http://muskie.usm.maine.edu/schoolreadiness/
6. Cooper J. Social and emotional development in early childhood: what every policymaker should know. New York: National Center for Children in Poverty, 2009. Available from: http://www.nccp.org/publications/

Karen Adamson, RN, MPH, is Program Manager for Children, Youth and Families at Hennepin County Human Services and Public Health (Minnesota) and she is the current Chair of the Minnesota Department of Health MCH Advisory Task Force. Karen received her MPH in Maternal and Child Health from the University of Minnesota.

Promoting Infant Mental Health through Relationship-based Interventions

Martha Farrell Erickson, PhD

The STEEP™ program (Steps Toward Effective, Enjoyable Parenting) aims to promote healthy parenting and prevent social-emotional problems among babies in families facing risk factors such as poverty, social isolation, or a history of troubled relationships. Attachment theory provides a framework for the program, and longitudinal research on factors that underlie healthy parent-child relationships informs the program's broad goals.[1]

STEEP™ Program Structure

Participants typically are recruited through obstetric clinics during pregnancy. Bi-weekly home visits, tailored to the needs and strengths of each family, continue until the child's second birthday. Shortly after the babies are born, mothers begin attending bi-weekly group sessions. Reflecting the relationship-based approach of STEEP™, each group is led by the person who conducts the home visits for those 8–10 families.

Group sessions begin with mother-child activities geared to the babies' stage of development. Then, following a casual meal, mothers gather for "mom talk," or discussions focused on their own personal growth and life goals. Although group meetings are for mothers and babies, fathers and other family members are included in home visits and periodic family events.

Grounded in Attachment Theory and Research

The primary pathway to a secure attachment and the foundation of infant mental health is parental sensitivity to a baby's cues and signals. With that in mind, STEEP™ promotes sensitivity and addresses factors that can undermine sensitive care. A centerpiece of the program is Seeing Is Believing™, a video-recording of parent-infant interaction for engaging parents in self-observation and discovery as they watch the video with their home visitor.[2] Through open-ended questions, the facilitator encourages parents to focus on what their babies are telling them and to recognize their own skills in adapting to their babies' needs. Video-recording helps to keep the parent-child relationship at the center of the intervention, provides a permanent record for monitoring progress, and is a valuable aid when facilitators seek supervision or consultation. The video becomes a treasured keepsake for the family and, according to many participants, is a powerful incentive to participate in the program.

The primary pathway to a secure attachment and the foundation of infant mental health is parental sensitivity to baby's cues and signals.

Babies know what they experience—whether mom and dad can be counted on to offer comfort when they cry, play with them when they're feeling sociable, and respect their privacy when they'd rather sleep than be tickled. Many factors underlie a parent's ability to sustain sensitive, responsive care. Although each family has unique strengths and challenges, some major factors deserve special attention in a program designed to promote sensitivity:

- ***Knowledge and understanding of child development.*** Sensitive care is grounded in knowledge about child development and understanding of the developmental meaning of key behaviors such as separation protest or toddler negativism. When parents lack that understanding, they often hold unrealistic expectations and get caught in a cycle of frustration and anger, attributing negative qualities to their child just because he or she is doing what children naturally do.
- ***Social support.*** For parents to respond sensitively to their children's needs, their own needs must be addressed. Some parents are socially isolated; they lack supportive friends or family members, and/or lack the skills or confidence to access supportive resources. Barriers to getting support may include lack of transportation and money. Sometimes parents are surrounded by family and friends who do not support good parenting and the best interest of the child. This is dramatically evident, for example, in families living in a culture of drug abuse. STEEP™ helps parents identify potential sources of support and develop the skills to use support effectively.
- ***Looking back, moving forward.*** Consistent with attachment theory and research on intergenerational transmission of parenting, an important part of STEEP™ is to help parents reflect on what they learned in their own early relationships and how that influences their responses to their children. Both in home visits and groups, STEEP™ creates a supportive environment in which parents reflect on their history, confront painful memories, and identify positive experiences to pass on to their children. Understanding that no one is a perfect parent, the focus is on leaving hurtful patterns behind and mustering all available resources to become a "good enough" parent. As described in the STEEP facilitators' guide,[3] group activities give parents permission to begin looking back so they can move forward. Home visits afford an opportunity for more personalized encouragement and support.

Broad Dissemination and Adoption

Since the development and evaluation of STEEP™ and Seeing Is Believing™ at the University of Minnesota, these programs have been used in varied settings in North America, Australia, and Europe. The approaches have been used effectively with several special populations, including indigenous families, women who abused substances during pregnancy, teen parents, mothers who are depressed, families identified as abusive or neglectful, and families of preterm, medically fragile infants.

For further information about this work, or to inquire about training for staff in your organization, contact the author at mferick@umn.edu.

REFERENCES

1. Egeland B, Erickson MF. Lessons from STEEP™: linking theory, research and practice for the well-being of infants and parents. In Sameroff A, McDonough S, Rosenblum K. editors. Treating parent-infant relationship problems: strategies for intervention. New York: Guilford, 2003, p. 213–242.
2. Erickson MF. Seeing is Believing™ Training DVD. Minneapolis, MN: Irving B. Harris Training Center, University of Minnesota, 2005.
3. Erickson MF, Egeland B, Simon J, Rose T. STEEP™ Facilitator's Guide. Minneapolis, MN: Irving B. Harris Training Center, University of Minnesota, 2002. .

Martha Farrell Erickson, PhD, retired in 2008 from her position as Director of the Irving B. Harris Training Programs in the Center for Early Education and Development in the College of Education and Human Development at the University of Minnesota. She continues to consult and speak throughout the U.S. and abroad on infant mental health, parenting, and evidence-based strategies for working with high-risk families. Dr. Erickson also appears regularly on TV and radio in the Twin Cities and, with her daughter, Erin Garner (a MCH student in the Maternal and Child Health Program at the University of Minnesota), hosts the weekly talk show, Good Enough Moms™.

Promoting Early Childhood Mental Health through Evidence-based Practice

Implementation of the *Incredible Years* in Ramsey County, Minnesota

Gael Thompson, MSW, LICSW

In 2004, the Amherst H. Wilder Foundation introduced the *Incredible Years* programs to the community. This set of evidence-based programs is designed to teach positive interaction skills, social problem-solving strategies, anger management, and appropriate school behaviors to young children. The programs also strengthen parent-child relationships and help parents develop positive behavior guidance strategies.

Mission of the Wilder Foundation

Wilder introduced the *Incredible Years* programs as part of their 100-year history of combining direct services, research, and community development to address the needs of the most vulnerable people in Ramsey County, Minnesota. Through more than 70 diverse programs and services, Wilder works with thousands of individuals every year to help them overcome barriers to learning, address mental health needs, live more independently, maintain affordable housing, and engage in their communities.

The Continuum of *Incredible Years* Programs

The *Incredible Years* programs have two foci: (1) comprehensive treatment programs for young children with early onset conduct problems, and (2) universal prevention programs to promote social competence and prevent young children from developing conduct problems in the first place. The curricula are designed for teachers, parents, and children. The development of materials was guided by developmental theory and fit into an intervention pyramid with levels of intervention corresponding to universal, selective, and indicated prevention programs, plus an additional treatment program.

Photo used with permissioin of The Wilder Foundation Early Childhood Programs

At Wilder, three of the *Incredible Years* programs have been implemented and two additional programs were added in November 2009:

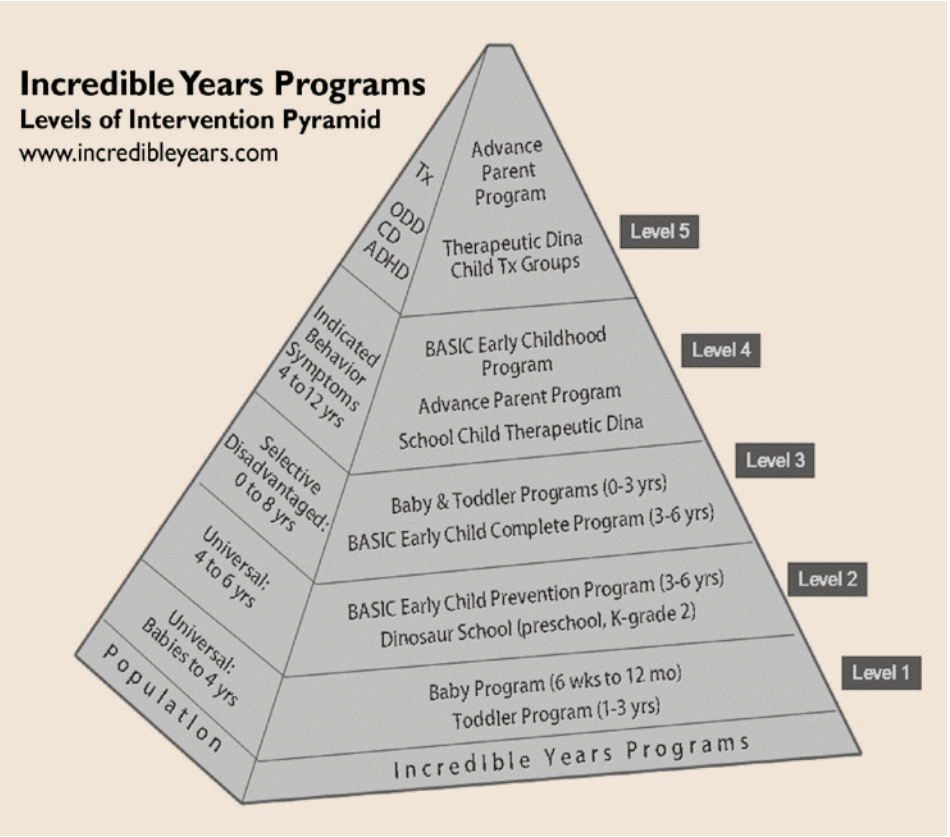
- ***Dina Dinosaur*** is a classroom-based prevention curriculum that teaches social problem-solving and self-regulation skills in order to prevent and reduce aggression at home and school (Level 2 of the intervention pyramid). It is delivered in the classroom two to three times a week in 15–20 minute circle time discussions followed by small group activities. For the past five years, the *Dina Dinosaur* curriculum has been implemented in Wilder's Child Development Center, an accredited full-day early child care and education program that works with some of the most vulnerable members in the community. In addition, Wilder trains and mentors other early childhood professionals to use the *Dina Dinosaur* curriculum, including those from Head Start, early childhood special education, and community-based child care centers.
- ***Dina small group therapy program*** is a treatment program (Level 5 of the pyramid) designed specifically for young children who show high rates of aggression, defiance, and oppositional or impulsive behaviors. It is delivered

in small group sessions for 20–22 weeks. In addition to the weekly therapeutic sessions for children, the *BASIC Parent Program* is offered to parents so they learn ways to foster healthy interactions at home similar to what their children are learning in the group.

- ***Preschool BASIC parent program*** is designed for parents of 3 to 6 year-olds. It focuses on strengthening children's social skills, emotional regulation, and school readiness skills. Parents are taught how to encourage cooperative behavior and how to use positive discipline by establishing rules, routines, and effective limit setting.
- ***Parents and babies program*** is designed for parents of infants (ages 0–12 months). The program focuses on helping parents learn to observe and read their babies' cues and learn ways to provide nurturing and responsive care, including physical, tactile, and visual stimulation as well as verbal communication.
- ***Parents and toddlers program*** is designed for parents of 1 to 3 year-olds. Parents learn how child-directed play promotes positive relationships, how to use emotion coaching to build children's emotional vocabulary and encourage their expression of feelings, how to build children's self-esteem through praise and encouragement, and how to teach age-appropriate self-care skills.

Program Outcomes

In 2009, Wilder Research completed an outcome report of data collected since implementing the *Incredible Years* programs (2005–2009). Children showed statistically significant improvements in all five behavioral domains: emotional symptoms, conduct problems, hyperactivity-inattention, peer problems, and pro-social behavior. Parents and teachers reported that fewer children had difficulties with emotions, concentration, behavior, or getting along with others at discharge compared to intake. Parents who participated in the *Preschool BASIC Parent Program* demonstrated significant improvement from intake to discharge in six of seven parenting skills areas: appropriate discipline, harsh and inconsistent discipline, positive verbal discipline, praise and incentives, physical discipline, and clear expectations.



National Award Recipient

On September 25, 2009, the Substance Abuse and Mental Health Services Administration announced that Wilder's *Incredible Years* Program was selected as one of 27 nation-wide recipients of their 2009 Science and Service Awards. These awards recognize exemplary implementation of evidence-based interventions that have been shown to prevent and/or treat mental illness and substance abuse.

For more information about the early childhood programs offered at the Wilder Foundation, go to www.wilder.org/432.0.html. For more information about the *Incredible Years* programs, please go to www.incredibleyears.com.

Gael Thompson, MSW, LICSW, is the Early Childhood Intervention Program Coordinator at the Amherst H. Wilder Foundation Child Guidance Clinic, St. Paul, MN.

continued from page 19 Family Home Visiting

REFERENCES

Visit www.health.state.mn.us/divs/fh/mch/fhv/index.html for information about the family home visiting program and www.health.state.mn.us/divs/fh/mch/fhv/newsletter/documents/summer2009.pdf for information about reflective practice.

REFERENCES

1. Powers S, Fenichel E. Home visiting: reaching babies and families "where they live." A report of the best available information from 20 years of research and practice on home visiting. Washington DC: Zero to Three, 1999.
2. Zeanah CH, Zeanah PD. Towards a definition of infant mental health. Zero to Three, 2001; 22(1):13-20.
3. Nursing Child Assessment Satellite Training (NCAST) AVENUW. Available from: http://www.ncast.org/
4. Miller W, Rollnick S. Motivational interviewing. preparing people for change, 2nd edition. New York: Guilford, 2002..

Sharon Hesseltine, BSW, is a Child Development/ Infant Mental Health Specialist in the Family and Community Health Division of the Minnesota Department of Health

Jill E. Simon, MSW, LICSW, IMH-E® (IV), is a Reflective Practice Consultant in the Family and Community Health Division at the Minnesota Department of Health.

Supporting the Mental Health Needs of Traumatized Young Children

Abigail Gewirtz, PhD, LP

A 2009 study by the U.S. Department of Justice indicates that children (birth to 17 years) experience astonishingly high rates of traumatic events.* Over 60% of children studied had experienced or witnessed at least one violent incident in the past year.[1] The youngest children—those ages birth to five—were most vulnerable to abuse, neglect, and exposure to domestic violence. Such young children are the most dependent on caregivers, and cannot report on their own traumatic experiences, complicating efforts to gather prevalence data.[1]

Risks Associated with Trauma

Several subgroups of very young children are at particularly high risk for exposure to traumatic events. These are young children with backgrounds indicating high adversity or exposure to multiple stressful events, and often the caregivers of these children also have been exposed to significant trauma. These childhood experiences include homelessness, having refugee parents who have fled war in their native countries, and having mothers fleeing domestic violence. An additional group emerging as high-risk includes children whose parent(s) have been deployed to combat duty in Iraq or Afghanistan. These "high-risk" families are less likely to access mental health or related services that might buffer poor parenting,[2] enhance social support, and increase child and family functioning.

Homeless and poor families. Families living in poverty—particularly those who are homeless—are most likely to be single-mother families with several young children. Children living in homeless families are significantly more likely to have health and social-emotional problems compared to poor children who have housing.[3]

Military families. Recent studies have shown increased risk of maltreatment among children in military families where a parent has been deployed to Iraq or Afghanistan.[4] Parents remaining at home are challenged by the stressors associated with being a sole caregiver and having a deployed partner in an unsafe environment. Reunions can also be stressful for all members of the family. Some returning soldiers may have posttraumatic stress disorder (PTSD), increasing both parenting and couple challenges. In the military, supports for active-duty service families are stronger than for families with caregivers serving in the National Guard or Reserves; the former tend to live in communities (or on bases) with better social supports and more resources.

Treatment for Traumatized Young Children

What can be done to support young, highly stressed families dealing with traumatic experiences? Over the past several decades, effective programs have been developed to both prevent and treat trauma-related problems in adults and children. SAMHSA's National Child Traumatic Stress Network (NCTSN) is a nationwide network of Centers dedicated to developing, disseminating, and implementing best practices in child trauma.[5] The NCTSN's

** Traumatic events include any event in which an individual experiences actual or threatened death, serious injury, the threat to physical integrity, or the life or integrity of a close associate. Examples include abuse, domestic violence, community violence, wars, natural disasters such as tornados or flooding, terrorism, or motor vehicle or other accidents.*

goal is to increase access to high-quality care for traumatized children and their families.

Parenting through change. Ambit Network is the NCTSN Center in Minnesota. A community-University partnership based at the University of Minnesota, Ambit includes multiple child-serving systems and agencies. Over the past four years, Ambit (formerly known as the MN Child Response Center) has trained hundreds of practitioners in Minnesota to increase their capacity to identify and provide services for traumatized children and families. The Center has focused on the implementation of two types of interventions—treatment for individual children and prevention to support parenting in traumatized families. The latter, *Parenting through Change (PTC)*,[6] is a 14-week group that enhances critical elements of parenting that may be adversely affected when families have experienced traumatic events. *PTC* has been implemented successfully in a shelter, at several supportive housing agencies, and at schools, in collaboration with several non-profit agencies (the Family Housing Fund and the Minneapolis Public Schools). In partnership with the Center for Victims of Torture and the East African Women's Center, a *PTC* group will begin with Somali mothers in Minneapolis in late 2009. Also in late 2009, a *PTC* group for returning military parents will be led by Ambit Network staff in partnership with the Minneapolis Veterans Administration Medical Center.

Trauma-focused cognitive behavioral therapy. For traumatized children ages three and older, *trauma-focused cognitive behavioral therapy (TF-CBT)*[7] is a treatment shown to be effective in multiple settings. Over the past three years, Ambit Network, in partnership with the Minnesota Department of Human Service, Division of Children's Mental Health, has trained and provided technical assistance to almost 100 mental health professionals across Minnesota to deliver *TF-CBT.*

Over the next three years, Ambit, in collaboration with Minnesota's Department of Human Services, will expand its efforts to develop a trauma-informed mental health system in Minnesota, to ensure that all children and families who have experienced traumatic events have access to the best services available.

For more information about the programs for traumatized children and families offered through Ambit Network, contact Ashley Wahl at 612-624-7722.

REFERENCES

1. Finkelhor D, Turner H, Ormrod R, Hamby S, Kracke K. Children's exposure to violence: a comprehensive national survey. Juvenile Justice Bulletin, Washington DC: Department of Justice, Office of Justice Programs, OJJDP Bulletin, 2009. Available from: http://www.ncjrs.gov/pdffiles1/ojjdp/227744.pdf
2. Gewirtz AH, Forgatch M, Wieling L. Parenting practices as potential mechanisms for child adjustment following mass trauma. J Marital Fam Ther 2008; 34(2):177–192.
3. Gewirtz AH, DeGarmo DS, Plowman E, August GJ. Parenting, parental mental health, and child functioning in families residing in supportive housing. Am J Orthopsychiatry, in press.
4. Gibbs DA, Martin SL, Kupper LL, Johnson RE. Child maltreatment in enlisted soldiers' families during combat-related deployments. JAMA 2007; 298:528-535.
5. National Child Traumatic Stress Network. Description, resources and products. Available from: www.nctsn.org
6. Forgatch MS, Patterson GR, DeGarmo DS, Beldavs ZG. Testing the Oregon delinquency model with 9-year follow-up of the Oregon divorce sudy. Dev Psychopathol 2009; 21:637-660.
7. Cohen J, Mannarino A, Deblinger E. Treating trauma and traumatic grief in children and adolescents. New York: Guildford Press, 2006,

Abigail Gewirtz, PhD, LP, is an Assistant Professor in the Department of Family Social Science and the Institute of Child Development at the University of Minnesota, and Director of Ambit Network.

Minnesota Early Childhood Comprehensive System (MECCS):

Building the Infrastructure to Meet Developmental Needs of Young Children

Kelly Monson MAEd, CFLE

Extensive research supports the importance of a comprehensive system of care and services for children in order for them to be ready for school.[1,2] Many state efforts to improve school readiness have focused on strengthening early learning services such as child care and preschool. However, to be prepared for school and the interaction of normal life situations, how young children *feel* and *behave* is just as important as what they *know* and *think*. All of these competencies are inextricably linked.

Moving from a Fragmented to a Comprehensive System

In most states, policies and programs that address the developmental needs of young children and their families are spread across government agencies, funded through different sources, and delivered through multiple public and private providers in communities.[1] This fragmentation is costly, inefficient, and most importantly, results in many needs of young children going unmet. In an effort to encourage comprehensive systems for young children 0–5 years and their families, the Health Resources and Services Administration initiated the State Early Childhood Comprehensive Systems (ECCS) grants in 2003. The purpose of ECCS grants is to integrate early childhood policies and programs, including funding streams. The systems to be integrated include key public, private, state, and local agencies that address five critical components of early childhood:

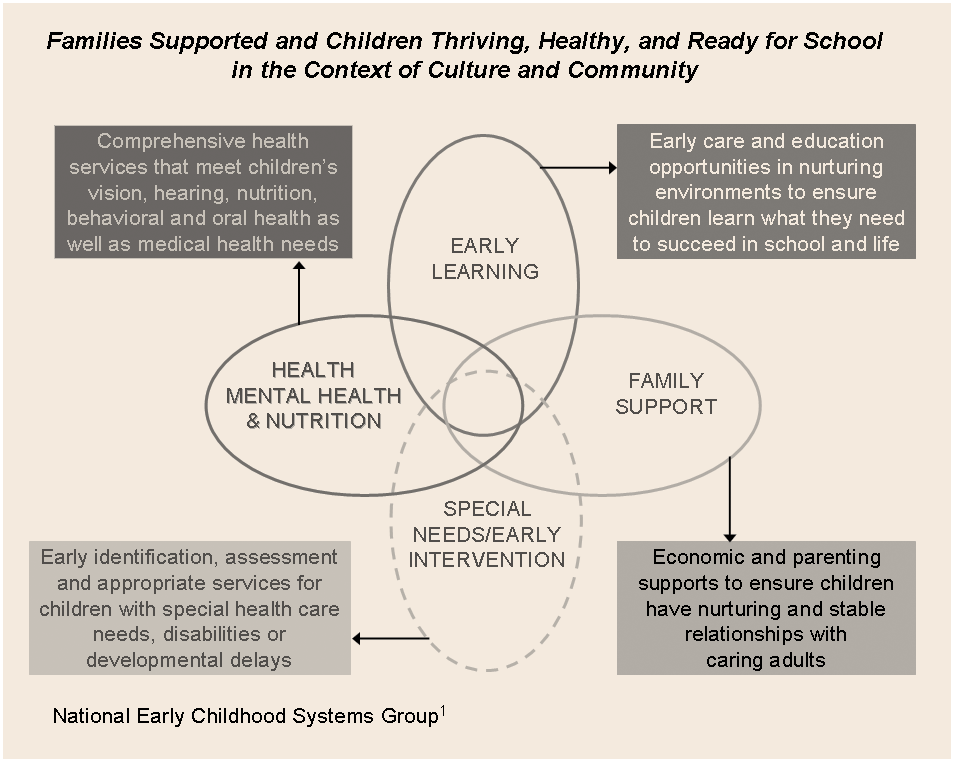
- Access to health insurance and medical homes;
- Mental health and social-emotional development;
- Early child care and education;
- Parenting education; and
- Family support.

The Minnesota Department of Health (MDH) has been an ECCS grantee since July 2003. The Minnesota Early Childhood Comprehensive System (MECCS) focuses on infrastructure and capacity building services and involves representatives of key units within the state departments of health, education, and human services whose work is directly related to the five critical components.

Adopting a Model for Systems Development

With this multi-sector partnership, Minnesota adopted the goal of "families supported and children thriving, healthy, and ready for school in the context of culture and community." In 2007, MECCS collaborated with Ready 4K, the state recipient of a national Build grant,[3] to adopt a model developed by the National Childhood Systems Working Group[1,3] that integrates the key systems necessary for early childhood development: (1) health, mental health and nutrition; (2) early learning; (3) family support; and (4) special needs/early intervention.[1,3]

The five essential elements of ECCS are represented by one or more of the four ovals in this systems model. While individual programs within any of the ovals may demonstrate some positive impact upon children's healthy development and school readiness, they will not realize their full potential without support from the programs in the other ovals.[1] By adopting a systems model, mental health was incorporated into early childhood systems-building in Minnesota. Ensuring positive mental health requires that children have good self-esteem, adaptive skills, and positive social behaviors with peers and adults—and that any developmental delays of children are recognized and treated.[1]



Key Indicators to Monitor an Early Childhood System

In collaboration with the Wilder Foundation, Minnesota Build and MECCS identified 22 indicators of child and family well-being and systems quality that represent each of the four ovals in the systems model.[4] Identification and ongoing measurement of indicators are critical because such data allow the state partners to:

- Track trends in young child and family well-being over time;
- Measure progress toward improving child outcomes;
- Improve programs for children and families;
- Inform state and local planning and policymaking;
- Monitor the impact of investments and policy choices;
- Improve data quality and availability of current and emerging indicators; and
- Expose and eliminate disparities by income and race/ethnicity.[4]

Some of the indicators selected that relate specifically to young children's mental health include:

- Number/percent of children with possible social-emotional problems identified and referred at early childhood screening;
- Number/percent of children being served through publicly funded mental health services compared to estimated need;
- Number of children ages 0–2 and 3–4 enrolled in quality early childhood programs;
- Participation rates in ECFE and other parent education and support models; and
- Number/percent of children birth to 3 years who are served through Part C Early Intervention.

Given the frequently voiced concern by both parents and professionals about the unmet social-emotional needs of young children, the infrastructure being developed through MECCS is an important step in the direction of filling this gap and improving the mental health of all young children in Minnesota.

For more information about MECCS, visit their website at: www.health.state.mn.us/divs/cfh/meccs/. For more information about the BUILD initiative, visit their website at: www.buildinitiative.org/

REFERENCES

1. Bruner C. Connecting child health and school readiness. Build Initiative and Child and Family Policy Center, February 2009. Available from: http://www.buildinitiative.org/files/IssueBrief_Bruner_Feb09_Final.pdf

2. Shonkoff J, Phillips D. (Eds.). National Research Council and Institute of Medicine. From neurons to neighborhoods: the science of early childhood development. Washington, DC: National Academy Press, 2000.

3. Build initiative: A project of the Early Childhood Funders' Collaborative supporting state efforts to prepare our youngest children for success. Available from: http://www.buildinitiative.org/

4. Moore C, Chase R, Waltz M, et al. Early childhood Minnesota Indicators and strategies for Minnesota's early childhood system, a joint report of Minnesota Build and Minnesota Early Childhood Comprehensive Systems. St. Paul: Wilder Research, 2008. Available from: http://www.wilder.org/download.0.html?report=2173

Kelly Monson MA Ed, CFLE, is a State Early Childhood Systems Coordinator at the Minnesota Department of Health, Community and Family Health Division.

Center for Excellence in Children's Mental Health

Linking University and Community Experts and Resources

Cari Michaels, MPH

The Center for Excellence in Children's Mental Health (CECMH) was established in 2003 as part of the University of Minnesota President's Initiative on Children, Youth, and Families. Its mission is to promote the mental health of Minnesota children, their families, and their communities by informing and integrating research, training, practice, and policy. Toward that end, CECMH staff work with University faculty, staff, and community members to improve children's mental health in the state of Minnesota.

Head Start Goals

Since its inception, CECMH has displayed a strong commitment to strengthening children's mental health by promoting the use of evidence in mental health practice and policymaking. CECMH also works with faculty members to promote publicly engaged research that is pertinent to the needs of community members.

In order to engage a wide range of providers, parents and researchers in training events, CECMH sponsors an annual *Lessons from the Field* seminar series that features local and national speakers. Seminars are video-streamed live to over 30 sites in Minnesota where participants view and listen to the speakers and participate in discussions. Each *Lessons from the Field* series is organized around a community-identified theme. Because of CECMH's strong interest in early childhood, the 2006–2008 seminars explored issues of attachment and its relationship to mental health, intervention, treatment methods, and intergenerational issues. The 2009–2010 series will focus on race, culture, and children's mental health.This series is co-sponsored by several partners, including the Center for Leadership Education in Maternal and Child Public Health.

CECMH also disseminates current, applicable, and accessible research to providers and policymakers. *CECMH eReview* is an online publication that features a summary of published research in a specific area and a collection of responses from providers and policymakers regarding the practical application of that research. The first issue, "Attachment Relationships and Adoption Outcomes," and all subsequent *eReview* issues are published on the CECMH website (www.cmh.umn.edu).

One of the most critical areas of CECMH work is to promote publically engaged research by building partnerships between research faculty and community members. CECMH staff bring University research expertise to bear on problems of significance to the community—facilitating the community's voice in guiding academic research. One example of this work is the CECMH's active participation in a Cultural Providers Network of local clinicians that serves children of color. This diverse group of dedicated providers incorporates research-based evidence into their work and develops new, culturally appropriate interventions.

CECMH is housed in the interdisciplinary Children, Youth, and Family Consortium (CYFC) at the University of Minnesota. For more information about CECMH and its projects, visit www.cmh.umn.edu or call (612) 625-7849.

Cari Michaels, MPH, is the Associate Director of the Center for Excellence in Children's Mental Health at the University of Minnesota.

SPEAKERS' SERIES CENTER FOR EXCELLENCE IN CHILDREN'S MENTAL HEALTH LESSONS FROM THE FIELD 2009-2010:

RACE, CULTURE AND CHILDREN'S MENTAL HEALTH

December 4, 2009, 9:00 a.m. – 12:30 p.m.
Historical Trauma, Microaggressions, and Identity: A Framework for Culturally Based Practice
Dr. Karina Walters

February 17, 2010, 9:00 a.m. – 12:30 p.m.
Intersection of Culture and Children's Mental Health in Working with Immigrant & Refugee Families

March 18th, 2010, 9:00a.m. – 12:30 p.m.
Promoting Child Well-being and Early Intervention within a Cultural Context
Brenda Jones Harden, University of Maryland

May 12, 2010, 1:30p.m. – 3:30 p.m.
Title TBD
Alicia Lieberman, University of California – SF

All sessions will be at the Coffman Theater, University of Minnesota and broadcast to sites in Greater Minnesota.

Sponsors: Center for Excellence in Children's Mental Health in partnership with Center for Advanced Studies in Child Welfare (UMN) and Harris Programs (UMN).

Co-sponsors: Center for Leadership Education in Maternal and Child Public Health (UMN), MN ADOPT, Office for Equity and Diversity (UMN), Minnesota Community Foundation-Baby Project, and Sheltering Arms Foundation.

For more information, visit: http://www.cmh.umn.edu/culture/workshop1.html.

Culturally Sensitive, Relationship-based Practice

Promoting Infant Mental Health

Competency-based Training and Endorsement

Candace Kragthorpe, MSW, IMH-E® (IV)

All providers and educators who work with young children and their families play critical roles in promoting optimal mental health outcomes for infants, toddlers, and preschoolers. Roles may include health promotion for all children, preventive intervention in at-risk situations, early intervention that addresses developmental concerns, and intensive services and treatment for children with serious emotional disturbances. Best practices for this population focus on supporting positive relationships between parent, child, and other caregivers in the context of a family's culture and community.

Training in Best Practices

Infant and family professionals require specialized professional development and consultation from infant mental health specialists to ensure service quality and effectiveness in addressing the diverse and often complex needs of infants, young children, and families.

The Minnesota Association for Infant and Early Childhood Mental Health (MAIECMH) is a statewide membership organization whose mission is to promote social and emotional development and mental health of children, from birth to 5 years. Founded in 2007 and affiliated with the World Association for Infant Mental Health, MAIECMH operates as the infant and early childhood division of MACMH (Minnesota Association for Children's Mental Health). The goals of MAIECMH include education and advocacy to enhance culturally sensitive interdisciplinary capacity to serve infants, young children, and their families.

Professional competencies. MAIECMH works to advance standards in practice among a range of professional disciplines working with infants, young children, and their families. These standards are grounded in comprehensive professional competencies based on infant mental health principles, as identified by the Michigan Association for Infant Mental Health (MI-AIMH). These principles include mutuality of caregiving relationships and understanding and using the rich histories, feelings, and behaviors that the child, parent/caregiver, and provider/educator bring to these working relationships.

Reflective practice. These principles require that professionals actively engage in a reflective stance via supervision and consultation. This reflective practice is an integral component of interventions provided along a continuum of care, from promotion and prevention to intensive treatment. Reflective supervision, provided regularly, leads to improved family outcomes, improved quality of services, and support for ethical practice and cultural competence.[1]

Endorsement. Professional competencies are the framework for a professional endorsement program offered in Minnesota by MAIECMH, called *Culturally Sensitive, Relationship-based Practice Promoting Infant Mental Health.* A number of states across the country offer the endorsement program, developed and copyrighted by MI-AIMH. Working with MI-AIMH, partner states, Minnesota organizations, and association members, MAIECMH is promoting and evaluating the application of these competencies among a range of practitioners, providers, and educators.

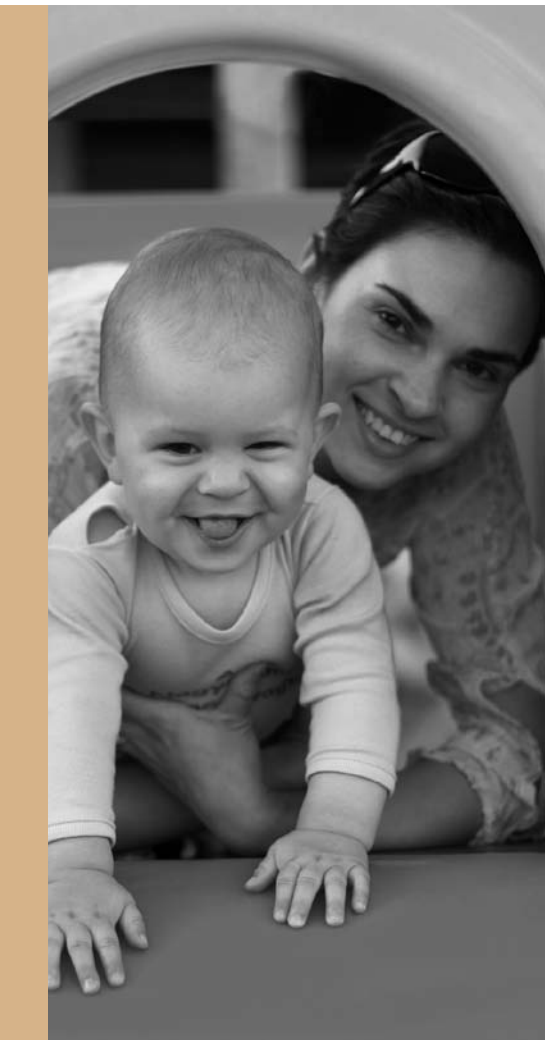
The set of professional competencies can be used to:

- Guide and encourage continuous professional development and career planning;
- Guide the development of pre-service

Continued on page 35

Bringing Order to the Complexity of Early Experience The Role of Training in Infant Mental Health

Elizabeth A. Carlson, PhD, LP



Early childhood is unique in the human life cycle for the rapidity and complexity of developmental change and transformation.[1] Typically, the infant progresses from complete dependence upon the caregiver to a mobile, cognitively sophisticated, self-regulating child who is capable of understanding and participating actively in the social world.[1,2] However, development in the early years is paradoxical; it is both highly robust and highly vulnerable, with cascading effects for later development.[3]

Conditions Necessary for Infant Mental Health

The well-being and well-becoming of young children (infant mental health) depend upon two essential conditions: (1) stable and loving relationships with a limited number of adults who provide responsive, regulatory experience, encouragement for exploration and learning, and transmission of cultural values; and (2) a safe and predictable environment that provides a range of growth-promoting experiences in cognitive, linguistic, social, and emotional domains.[3] While the majority of children experience the benefits of both, significant numbers do not.

The Need for Training Specific to Infant Mental Health

The many practitioners engaged in addressing the needs of young children and their families often face a host of challenges, including the need to move beyond their own professional training and experience. Well-defined training within one age range (e.g., middle childhood, adolescence) or within one discipline (e.g., education, nursing, social work) often does not equip providers to address the complex needs of the birth-to-three population and their family life circumstances, such as family stressors, issues associated with poverty, and/or cultural diversity. Moreover, domain-specific training may not prepare professionals to work across disciplines nor to develop a shared perspective or language about development and practice. As a result, providers and interventionists report feeling isolated, ineffective, and overwhelmed by the work.[4]

Ongoing evaluation research highlights the need for a common understanding of early development and the social contexts in which development unfolds, as well as the association between specialized training and higher quality care and intervention outcomes.[3,4] Recent competency systems,[5,6] including the Minnesota Association of Infant and Early Childhood Mental Health (MAIECMH) endorsement process, provide important guidelines for higher education institutions and other organizations in establishing effective training programs.

Competencies needed. Training itself is complex and involves a developmental process including multiple levels of experience.[7] Practitioners must acquire:

- A knowledge base from which to understand infants and toddlers, the adults who care for them, and early relationship development;
- Skills of observation, assessment, and intervention, and guidance in their application; and
- Opportunities for reflection with a training supervisor who is knowledgeable about early development and able to help sustain the work.

Similar to processes of change or learning in other domains, the professional development of skilled workers, teachers, and interventionists in early childhood necessitates more than new information or a new technique. It requires a transformation or shift in understanding of the nature of early experience and its role in later functioning.

continued from page 33
Promoting Infant Mental Health

Professional Development Program at the University of Minnesota

As one of a number of training programs in the U.S., the University of Minnesota's 2-year post-baccalaureate Infant and Early Childhood Mental Health certificate program provides a professional development opportunity for early interventionists and an illustration or model of a process-oriented approach to training. The program is designed for front-line service providers (e.g., public health nurses, early childhood and family educators, child welfare workers, home visitors) and credentialed mental health professionals who wish to build their knowledge and skills in early childhood mental health, dyadic or triadic treatment, and reflective consultation. The Institute of Child Development, the academic home of the program, offers graduate credits applicable to advanced degrees; alternatively, participants may complete the program for professional continuing education units.

…the professional development of skilled workers, teachers, and interventionists in early childhood requires a transformation or shift in understanding of the nature of early experience and its role in later functioning.

The comprehensive series of courses and experiences provides a background in early development, experience in observation and assessment, guidance in the application of developmental principles to prevention/intervention, and reflective practice regarding the experience of families that are served and the interveners who serve them. Informed by developmental research and theory, the training program attends to principles and processes that underlie both typical and atypical development in early childhood. From this framework, child behavior is viewed as an adaptation constructed over time, a product of regulatory history and current environmental challenges and supports. Such a developmental perspective brings order to the complexity of early experience. Interdisciplinary training in development facilitates communication and coordination across domains, provides direction in practice, and instills hope in work with children and families.

For more information about the Infant and Early Childhood Mental Health certificate program, contact Sara Zettervall (612-625-2252) or visit their website: www.cehd.umn.edu/ceed/profdev/certificateprograms/IECMH/default.html

REFERENCES

1. Sroufe LA. (1996). Emotional development: the organization of emotional life in the early years. New York: Cambridge University Press, 1996.
2. Zeanah CH (Ed.). Handbook of infant mental health, 3rd edition. New York: Guilford Press, 2009.
3. Shonkoff J P, Phillips DA. From neurons to neighborhoods: the science of early childhood development. Washington, D.C.: National Academy Press, 2000.
4. Erickson MF, Kurz-Riemer K. Infants, toddlers, and families: a framework for support and intervention. New York: Guilford Press, 1999.
5. Korfmacher J, Hilado A. Creating a workforce in early childhood mental health: defining the competent specialist. Research Report from the Herr Research Center for Children and Social Policy at Erikson Institute, 2008. Available from: http://www.erikson.edu/hrc
6. Weatherston DJ, Dowler Moss B, Harris D. Building capacity in the infant and family field through competency-based endorsement: three states' experiences. Zero to Three 2006; 26(3):4-13.
7. Fraiberg S. Clinical studies in infant mental health. New York: Basic Books, 1980.

Elizabeth A. Carlson, PhD, LP, is Director of the Harris Programs and is a Research Associate at the Institute of Child Development, University of Minnesota.

and continuing education curricula;

- Document and demonstrate to families, colleagues, employers, and funders a professional's growing proficiency in specialized knowledge and skills;
- Enhance staff development activities;
- Promote effective, culturally-sensitive program development;
- Inform policy development and systems enhancements; and
- Identify research agendas.

Endorsement for *Culturally Sensitive, Relationship-based Practice Promoting Infant Mental Health* is available to providers, clinicians, and educators who work in a range of settings and disciplines at four professional levels spanning the continuum of care.[2] Depending on the education and experience of the professional, competencies include:

1. theoretical foundations
2. law, regulation and policy
3. systems expertise
4. direct service, reflection and leadership skills and
5. research and evaluation.

For more information about endorsement:

Contact MAIECMH staff at 651-644-7333 or 1-800-528-4511

Continuing requirements for endorsement include MAIECMH membership and 15 hours annually of related training approved by MAIECMH. A central registry of endorsees and consultants is maintained at the MACMH office, 165 Western Avenue North, Suite 2, St. Paul, MN 55102

REFERENCES

1. Lamb-Parker F, LeBuffe P. A strength-based, systemic mental health approach to support childen's social and emotional development. Infants & Young Children 2008;21(1):45-55.
2. MAIECMH Endorsement for Culturally Sensitive, Relationship-based Practice Promoting Infant Mental Health. Available from: http://www.macmh.org/maiecmhweb/2PageEndorsemntFlyer.pdf

Candace Kragthorpe, MSW, IMH-E® (IV), is Director of the Minnesota Association for Infant and Early Childhood Mental Health (MAIECMH), a Division of MACMH.

Interested in Making a Difference?

Consider a Master's in Public Health (MPH) degree in Maternal and Child Health (MCH)

For Lauren Gilchrist, a typical day at work always has "an exciting element of the unexpected." Gilchrist is a health policy advisor for Minnesota Senator Al Franken. As the nation is engaged in a debate about health care reform, it is not surprising that Capitol Hill would provide a stimulating professional venue for this recent MCH Master's of Public Health graduate.

A native of Rochester, Minnesota, home of the world-renowned Mayo Clinic, Gilchrist grew up believing that people "deserve a high standard of health care and health status." After graduating from Wesleyan University, Gilchrist pursued this view, working for several years in direct services with underserved communities. That experience gave Gilchrist perspective about the day-to-day challenges confronting disenfranchised people. To Gilchrist, "direct services were rarely getting to the root of problems…I felt like I was putting band-aids on things instead of helping problems be resolved or improved in a larger sense."

Gilchrist pursued a degree in public health because she wanted to use research and policy as tools to make systemic changes to improve people's lives. Through the MCH Program at the University of Minnesota, Gilchrist was able to take classes about the health of children and families and develop strong analytic and quantitative skills through the program's epidemiology emphasis curriculum.

Particularly influential in her current work as a policy advisor are the skills Gilchrist gained in epidemiology and program evaluation as a student in the MCH program. Her training in epidemiology gave Gilchrist the "ability to look critically at research" and assess its quality. The skills she developed in program evaluation help her to determine if a policy has accountability.

"The hands-on experience and historical perspective on policy as a strategy for public health" that Gilchrist received through Jean Forster's legislative advocacy classes gave her a way to pull all of her skills together. During her MCH training, she spent a semester working with the state legislature at the Children's Defense Fund of Minnesota. Through that experience she realized that public policy work was a good fit for her skills and personality.

After receiving her MPH in 2007, Gilchrist worked as the Outreach Director for the Deborah E. Powell Center for Women's Health at the University of Minnesota, where she planned programs to promote the health of women and girls. In 2008, Gilchrist received a one-year Health Policy Fellowship from the Association of Schools of Public Health. Her placement with the late Senator Ted Kennedy on the U.S. Senate Committee for Health, Labor, Education, and Pensions helped her transition from designing public health programs and working on state policy to working on policy at the federal level.

After her Fellowship Gilchrist began work with Minnesota Senator Al Franken. Her position offers "a great opportunity… to be tied to what is going on…in [Washington] D.C…and at the same time…work on Minnesota issues." Gilchrist spends her time meeting with Minnesota constituents, collaborating with other Senate offices, and drafting and evaluating original legislation to develop and support policies that will "enhance the health of Minnesotans." Gilchrist's experiences as a Minnesotan, a public health professional, and a specialist in maternal and child health give her a unique perspective on health policy: "I look at everything through a Minnesota lens, a public health lens, and…an MCH lens. And I use that as a way to evaluate policy opportunities, and to frame ideas that we are thinking of putting forth or supporting ideas that other folks have put forth."

Gilchrist's work with Senator Franken is a good fit because the health of women and children throughout the life course are among his policy priorities. According to Gilchrist, "maternal and child health issues are critically important when we are designing public health programs…and policy. Also, when we are looking at health care reform, we want to make sure…that everything we do is in the best interest of maternal and child health because we know that those investments have the greatest pay-off in the long run."

Gilchrist's future goals in her position are "to pass national health care reform and make sure it is implemented in a way that will be most beneficial to Minnesotans." Additionally, Gilchrist hopes to "continue to make our country a more prevention-focused place," so that discussions about health care reform are a jumping-off point for a movement towards health promotion, health maintenance, and addressing barriers to optimal health at the community level.

Learn more about getting an MPH in Maternal and Child Health, visit:

www.sph.umn.edu/education/mch/home.html

email: Kathryn Schwartz, schwa139@umn.edu

Website Resources for Early Childhood Mental Health

In addition to the websites identified in this issue's articles, the following list provides additional select web resources related to early childhood mental health and social-emotional development.

American Academy of Pediatrics advocates at the federal and state level for children's mental health as well as provides informational resources to parents and professionals about the behavioral and mental health of infants and young children. ***www.aap.org***

Bright Futures is a national initiative that seeks to strengthen the connection between state and local programs, health and service providers, and families through cross-agency training and distance-learning curricula related to children's mental health. ***www.brightfutures.org***

Center for Early Education and Development (CEED) and the Irving B. Harris Training Center for Infant and Toddler Development at the University of Minnesota support the social-emotional development of young children throughout Minnesota through applied research on infant mental health, trainings to help educators address challenging behaviors, and outreach to promote quality early child care. ***www.cehd.umn.edu/ceed***

Center on Social and Emotional Foundations of Early Learning (CSEFEL) is a national resource center that provides training materials, videos, and print resources to help early child care, health, and education providers implement the Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children. ***www.vanderbilt.edu/csefel***

Georgetown University Center for Child and Human Development provides national technical assistance, trainings, and policy resources, and conducts research and evaluation to address mental health needs of young children. ***www.gucchd.georgetown.edu***

Minnesota Association for Family and Early Education (MNAFEE) is a membership organization that offers professional development meetings, conferences, and networking opportunities to providers and coordinators of early childhood education throughout Minnesota. ***www.mnafee.org***

National Center for Children in Poverty at Columbia University's Mailman School of Public Health, conducts research on states' efforts to maximize polices to provide services that effectively promote social and emotional development in early childhood, particularly for at-risk children. ***www.nccp.org***

National Early Childhood Technical Assistance Center (NECTAC) is supported by the U.S. Department of Education's Office of Special Education Programs to strengthen service systems to ensure that children with disabilities (birth through 5 years) and their families receive and benefit from high quality, culturally appropriate, and family-centered supports and services. ***www.nectac.org***

Social and Emotional Development in Children and Adolescents–MCH Knowledge Path offers a selection of recent scientific research about the promotion of healthy social and emotional development in young children as well as tools for keeping up-to-date with new research. ***http://www.mchlibrary.info/knowledgepaths/kp_mental_healthy.html***

Technical Assistance Center on Social Emotional Interventions (TACSEI) translates research on effective practices for improving the social and emotional health outcomes for young children into free products and resources to help caregivers and service providers apply best practices in their everyday work. ***www.challengingbehavior.org***

Zero to Three provides resources for parents and professionals on social-emotional development and mental health of young children as well as information for policymakers and advocates on relevant public policy initiatives and advocacy opportunities. ***www.zerotothree.org***

Center for Leadership Education in Maternal and Child Public Health
School of Public Health
Division of Epidemiology and Community Health
University of Minnesota
1300 So 2nd St Suite 300
Minneapolis, MN 55454
www.epi.umn.edu/mch

Nonprofit Org.
U.S. Postage
PAID
Mpls., MN
Permit No. 155

Save these dates

for upcoming conferences and events

DECEMBER 2, 2009
National Children's Study Speakers Series
Fatherhood in the 21st Century: From Pregnancy Planning to Parenting
Robert "Clarence" Jones, MA; Community Outreach Director, Southside Community Health Services/Q Health Connections
3:00–4:30 p.m., FREE
Wilder Center, 451 Lexington Parkway North, St. Paul, MN
Sponsors: National Children's Study, Center for Leadership Education in Maternal and Child Public Health
Registration: Laurie Ukestad, *ukest001@umn.edu*

DECEMBER 4–6, 2009
The National Federation of Families for Children's Mental Health Conference
Children's Mental Health Matters
Washington, D.C
Registration: *www.ffcmh.org/*

DECEMBER 4–6, 2009
National Training Institute: Zero to Three
Dallas, TX
Registration: *www.zttnticonference.org/registration.aspx*

JANUARY 13–15, 2010
Strong Foundations Conference & MN Fatherhood Summit
Engaging Fathers – Strengthening Families
Arrowwood Resort, Alexandria, MN
Sponsors: Minnesota Departments of Health, Education and Human Services; MN Fathers and Families Network, CEED, Center for Leadership Education in Maternal and Child Public Health
Registration: *www.regonline.com/strongfoundations2010*

JANUARY 20, 2010
National Children's Study Speakers Series
Fetal Origins of Adult Disease
Kristin Oehlke, MS, CGC; State Genomics Coordinator, Minnesota Department of Health
3:00–4:00 p.m., FREE
Wilder Center, 451 Lexington Parkway North, St. Paul, MN
Sponsors: National Children's Study, Center for Leadership Education in Maternal and Child Public Health
Registration: Laurie Ukestad, *ukest001@umn.edu*

JANUARY 25–27, 2010
Child Welfare League of America National Conference
Children 2010: Leading a New Era
Marriott Wardman Park Hotel, Washington, D.C.
Registration: *www.cwla.org/conferences/conferences.htm*

MARCH 6-10, 2010
Association of Maternal and Child Health Programs
Annual Conference
Washington, D.C.
Registration: *www.amchp.org/conference*

Subscribe to our Children, Youth, and Family Health Listserv

Subscribe to our Children, Youth, and Family Health Listserv that shares resources and enhances networks among multidisciplinary professionals who work to improve the health and well-being of children, adolescents, families, and communities. To sign up send a message to: listserv@lists.umn.edu. Leave the subject line blank. In the body of the text write: Sub cyfhealth YOUR FIRST AND LAST NAME (example: sub cyfhealth Mary Jones). You will receive an email asking you to confirm your request.