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Editors
Cheri J. Shapiro
Institute for Families in Society
University of South Carolina
Columbia, SC
USA

Charlyn Harper Browne
Center for the Study of Social Policy
Washington, DC
USA

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Preface

In this volume, we adopt a systems-contextual view of supporting families of young children. Raising happy, healthy, competent, and confident young people requires environments at many levels that support positive development. This means parents and caregivers who understand how to help children grow and thrive, accessible and effective supports for parents and caregivers in need, early care and education settings that are loving and interesting, healthcare providers that take a keen interest in promoting overall child well-being, neighborhoods that are safe, nurturing, and supportive, and public policies that enable and support caregivers to focus on the best for their children. Together, we will explore these many facets to promote and strengthen outcomes for families of young children.

Chapters in this volume are organized to reflect multiple levels of the social ecology for children. We begin with the most proximal environments, including parents and early care and education providers. We then move to more distal but nonetheless critical environments, including primary healthcare settings and neighborhoods. We then turn to the fabric within which all environments are embedded—the policy environment. Lastly, we respond with a summary and call to action, helping us to pave the way for building and promoting strong supports for families of young children well into the future.

Throughout this volume, we will stand on the shoulders of giants, remembering that we can imagine and hope while simultaneously acting in a way to change the world for families of young children for the better. Use this volume well.

Columbia, USA — Cheri J. Shapiro
Washington, USA — Charlyn Harper Browne

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Contributors

Melissa Lim Brodowski Office of Early Childhood Development, Administration for Children and Families, US Department of Health and Human Services, Washington, DC, USA

Chrissie Castro Los Angeles/City County Native American Indian Commission, Los Angeles, CA, USA

Joyce Elizabeth Dean Dean/Ross Associates, Eugene, OR, USA

John C. Duby Department of Pediatrics, Wright State University Boonshoft School of Medicine, Dayton Children's Hospital, Dayton, OH, USA

Charlyn Harper Browne Center for the Study of Social Policy, Washington, DC, USA

Panu Lucier Crane Song Consulting, Anchorage, AK, USA

Megan C. Martin Center for the Study of Social Policy, Washington, DC, USA

Steven Rider Pacific Research and Evaluation, Portland, OR, USA

Shannon Rudisill Administration for Children and Families, US Department of Health and Human Services, Washington, DC, USA

James T. Seymour Catholic Community Services of the Mid-Willamette Valley and Central Coast, Salem, OR, USA

Cheri J. Shapiro Institute for Families in Society, College of Social Work, University of South Carolina, Columbia, SC, USA

M. Kay Teel University of Colorado, Denver, CO, USA

The Strengthening Families Approach and Protective Factors Framework™: A Pathway to Healthy Development and Well-Being

Charlyn Harper Browne

The Strengthening Families Approach and Protective Factors Framework™ was introduced by the Center for the Study of Social Policy in 2003 as an initiative for preventing child abuse and neglect in families of children birth—5 years old. Since its introduction, the Strengthening Families Approach and Protective Factors Framework has been implemented in states in one or more key areas, in addition to child abuse and neglect prevention, specifically early care and education, home visiting, and child welfare. At the core of the Strengthening Families approach are five protective factors which research suggests mitigate the effect of exposure to risk factors and promote healthy family and child development and well-being. Although the Strengthening Families approach is most often implemented in contexts that serve children and families whose circumstances increase the likelihood of poor outcomes, the five protective factors are regarded as essential to help keep all families strong. The protective factors of focus in the Strengthening Families approach are: parental resilience, social connections, knowledge of parenting and child development, social and emotional competence of children, and concrete support in times of need. This chapter will describe the research at the foundation of this approach and the five protective factors and recommendations for application in child- and parent-serving programs.

Background

Research in the fields of neuroscience, pediatrics, and developmental psychology has provided extensive evidence that the nature and quality of young children's earliest environments, relationships, and experiences influence whether the devel-

C. Harper Browne (✉)
Center for the Study of Social Policy, Washington, DC, USA
e-mail: charlyn.harperbrowne@cssp.org

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oping brain will have a strong or weak foundation for later cognitive, social, and emotional development (Center on the Developing Child at Harvard University 2010; National Scientific Council on the Developing Child 2007, 2010; Shonkoff et al. 2012). Studies show that early growth-promoting environments (e.g., adequate nutrition, regularly scheduled periods of sleep, and opportunities for physical activity), coupled with consistently nurturing and responsive care, prepare the developing brain to function optimally. Conversely, inadequate early environments, relationships, and experiences—such as child abuse and neglect—can be detrimental to the developing brain (National Scientific Council on the Developing Child 2007).

Early childhood is the period in which children are at greatest risk of experiencing abuse or neglect (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau 2015) and are most vulnerable to the effects of abuse or neglect (Shonkoff et al. 2012). Studies have found a relationship between child maltreatment and a broad range of developmental problems that can have both an immediate and enduring impact on learning, logical reasoning, socialization, emotional expression, and executive functions, if not properly addressed (Pynoos et al. 2007; Shonkoff et al. 2012; Ziegler 2011). Early childhood is also the period of greatest opportunity for preventing or mitigating adverse experiences and re-setting the developmental trajectory of traumatized young children toward more adaptive outcomes via interventions that shift the balance between risk factors and protective factors (Brazelton and Greenspan 2000; National Scientific Council on the Developing Child 2010; National Research Council and Institute of Medicine 2000).

Strengthening Families: A Primary Prevention and Promotion Approach

The Strengthening Families Approach and Protective Factors Framework™ (Strengthening Families) was introduced by the Center for the Study of Social Policy in 2003 as a research-informed initiative for preventing child abuse and neglect in families of children birth—5 years old. While the focus of traditional prevention efforts is on risk factors and the goal is to reduce the likelihood of the recurrence of child maltreatment once it has already happened in a family, the Strengthening Families approach is consistent with numerous researchers' recommended shift in the field of child maltreatment to a primary prevention and promotion approach (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention 2014; Stagner and Lansing 2009). That is, the Strengthening Families approach focuses on increasing family protective factors, and not singularly on decreasing risk factors, as a pathway to reduce the likelihood of child maltreatment before it occurs, and to strengthen the

capability of parents[1] to care for their children and themselves in ways that promote healthy development and "well-being."

Although there is no single agreed definition of well-being, the Administration for Children and Families, Administration on Children, Youth and Families, U.S. Department of Health and Human Services (2012) identified four domains of well-being that contribute to healthy functioning and success across the life span, specifically cognitive functioning, physical health and development, emotional/behavioral functioning, and social functioning. The Center for the Study of Social Policy (2013) asserts that the defining pathway to a child's well-being extends beyond this multidimensional conceptualization to include the influence of healthy family relationships and caregiving contexts, attachment to a caring and reliable adult, and positive parenting.

At the core of the Strengthening Families approach are five protective factors which research suggests mitigate the effect of exposure to risk factors and promote healthy family and child development and well-being. Although the Strengthening Families approach is most often implemented in contexts that serve children and families whose circumstances increase the likelihood of poor outcomes, the five protective factors are regarded as essential to help keep all families strong. The five protective factors are *parental resilience*, *social connections*, *knowledge of parenting and child development*, *concrete support in times of need, and social and emotional competence of children*; see Table 1.

Table 1 Definitions of the Strengthening Families protective factors

Protective factor	Definition
Parental resilience	Managing both general life and parenting stress and functioning well when faced with stressors, challenges, or adversity; the outcome is positive change and growth
Social connections	Having healthy, sustained relationships with people, institutions, the community, or a force greater than oneself
Knowledge of parenting and child development	Understanding the unique aspects of child development; implementing developmentally and contextually appropriate best parenting practices
Social and emotional competence of children	Providing an environment and experiences that enable the child to form close and secure adult and peer relationships, and to experience, regulate, and express emotions
Concrete support in times of need	Identifying, seeking, accessing, advocating for, and receiving needed adult, child, and family services; receiving a quality of service designed to preserve parents' dignity and promote healthy development

[1]"Parent" is used throughout this chapter to refer to an adult or adolescent who has responsibility for rearing a child, including the biological parents, grandparents, other relatives, or non-biological caregivers.

Foundational Perspectives of the Strengthening Families Approach

The research that originally informed the development of the Strengthening Families approach has burgeoned since the introduction of this approach and protective factors framework. These advances in knowledge have deepened understanding about early brain development, social determinants of health, the developmental impacts of trauma, and the pathways to child and family well-being. Also, these advances have further informed four major perspectives that serve as the foundation of the Strengthening Families approach, specifically (a) the two-generation approach, (b) the biology of stress, (c) the strengths-based perspective, (d) cultural competence and humility, and (e) resilience theory (Harper Browne 2014).

The Two-Generation Approach

Strengthening Families is a two-generation approach[2] in that it is designed to promote young children's healthy development by developing the capabilities and resources of their parents and caregivers. Although implementing a two-generation approach in the delivery of human services is not new, Gruendel (2014) asserted that in policy, programs, and practice, most of the focus has been on either children or parents. Thus, there is growing emphasis in many disciplines that the prevention of poor child outcomes and the promotion of healthy child development and success in life are inextricably tied to the capabilities and resources of parents (Shonkoff 2013).

The growing emphasis on the importance of a two-generation approach is informed by neuroscience research which demonstrates that nurturing and responsive parent–child interactions and relationships are critically important for healthy early brain development, while experiences that result in excessive stress—such as hostile parental care or exposure to family violence—can disrupt early brain development (Center on the Developing Child at Harvard University 2009; National Scientific Council on the Developing Child 2004a, 2005/2014, 2007, 2010). This growing emphasis is also informed by research on the social determinants of physical and mental health (e.g., safe housing; access to educational, economic, and job opportunities; family income; racism). Studies have found that social determinants of health can significantly impact the quality of the environments to which young children are exposed, parents' mental health, and, subsequently, the nature of children's development (Adamu et al. 2014; American Psychological Association 2015a; Brooks-Gunn and Duncan 1997).

[2]The two-generation approach is also referred to as a dual-generation, multigeneration, or whole family approach (Gruendel, 2014).

Two-generation strategies that are commonly implemented in early care and education settings, as well as human services programs (The Center for High Impact Philanthropy 2015), and that are consistent with strategies for helping families to build the Strengthening Families protective factors, include:

1. Addressing the needs of children and parents simultaneously through direct provision of a range of services, such as connecting parental employment programs to high quality early learning programs and health care.
2. Building parents' caregiving knowledge and skills in order to strengthen parent–child relationships.
3. Helping parents to find ways to effectively meet personal challenges and those in relation to their child, manage stressful situations, and help ensure they and their families are on a trajectory of healthy, positive outcomes.

The Biology of Stress

The Strengthening Families approach is informed by neuroscience research such as the biology of stress and early brain development. Across the life span, individuals can be faced with challenges that may be perceived as mild, moderate, or traumatic stressful experiences. When individuals are faced with stressors, the brain automatically triggers the stress response system—a series of bodily changes such as an increase in heart rate and blood pressure—and they experience negative emotional responses (e.g., anxiety, fear), as well.

Understanding the impact of stressors and stress on development is critically important in facilitating the building of relationships and the creation of environments that support well-being in parents and children. For example, Perry and Hambrick (2008) reported that exposure to consistent, predictable, nurturing, and enriched experiences promotes the development of neural structures and capabilities in young brains that increase children's chances for healthy development, well-being, productivity, and creativity. Conversely, exposure to neglectful, abusive, or horrifying environments adversely impacts developing brains, which increases children's chances for significant problems in all domains of functioning.

The National Scientific Council on the Developing Child (2005/2014) classified three types of stress responses in young children—positive, tolerable, and toxic—which are differentiated by the frequency, intensity, and duration of the stressor, as well as the availability of a caring, supportive adult (Shonkoff et al. 2012).

- Positive stress is experienced when children are faced with moderately challenging life events (e.g., meeting new people, being immunized) that result in brief stress responses in the context of stable and supportive child–adult relationships. Positive stress is beneficial to children because they have an opportunity to learn how to manage their emotions and behavior, as well as develop coping strategies, in response to moderate challenges (Gunnar et al. 2009).

- Tolerable stress is experienced when children are faced with more severe challenges (e.g., parental divorce, serious injury) that result in bodily changes that are stronger and have the potential to become toxic. Stress responses to severe challenges remain tolerable in the presence of protective adult relationships that facilitate the child's adaptive coping (Shonkoff et al. 2012, p. 236).
- Toxic stress is experienced when there is intense and sustained activation of the stress response system due to exposure to horrific, uncontrollable events or conditions (e.g., sexual abuse, parental addiction) and supportive relationships and environments are not available. Toxic stress reactions tend to persist and affect children's daily lives after the traumatic events have ended (National Child Traumatic Stress Network 2003).

Although all children will experience moderate stressors from time to time, it is estimated that 26 % of American children will witness or be victimized by a traumatic event and experience toxic stress before age 4 (Briggs-Gowan et al. 2010). Research on the biology of stress has found that toxic stress can disrupt healthy early development and have damaging effects on later learning, behavior, and health (National Scientific Council on the Developing Child 2005/2014). The effects of toxic stress that become evident during later developmental periods include having difficulty regulating emotions, forming healthy relationships, controlling thoughts and actions, managing stressful situations, and planning for the future (Langford and Badeau 2013). But research has also shown that supportive parenting and other positive relationships can promote positive adaptation, even if a child is exposed to adverse conditions that create toxic stress (Easterbrooks et al. 2013).

The Strengths-Based Perspective

Strengthening Families is a strengths-based approach for working with parents, children, and families. Implementing a strengths-based approach requires a philosophical shift away from a traditional deficits perspective which defines parents, children, and families in terms of their limits, problems, and risk factors that can be "fixed" only by experts (Grant and Cadell 2009; Maton et al. 2004; Saleebey 2006). A deficits-based perspective implicitly communicates low expectations and a high probability of failure (Abrams and Ceballos 2012). In addition, Skodol (2010) asserted that deficits-based interventions do not sustain change.

Conversely, a strengths-based perspective is based on the assumption that all individuals and families possess competencies and resources that should be identified, appreciated, and mobilized, regardless of the number or level of adverse conditions they are experiencing (Saint-Jacques et al. 2009). Strengths-based approaches (a) make families feel valued and respected, which increases the likelihood of more parent engagement in program services; (b) increase families' sense of efficacy and empowerment; and (c) enhance families' ability to form strong

relationships and social connections (Green et al. 2004). Several researchers have identified key guiding principles of a strengths-based approach (Grant and Cadell 2009; Green et al. 2004; Saint-Jacques et al. 2009), all of which are reflected in the Strengthening Families approach:

1. All people have the inherent capacity to learn, grow, and change.
2. Practitioners must be sensitive and responsive to parents' cultural backgrounds, values, and beliefs.
3. Individuals must be active participants in the change process and not simply passive recipients of information and services.
4. With a strengths-based approach that also focuses on building protective factors, parents can identify and build on their own strengths in order to enhance their parenting capabilities.
5. Individuals must be encouraged and allowed to use their voice to advocate for themselves and their children and to share in decision making, in order to have a sense of control over their life.
6. A mutually respectful practitioner–client relationship is essential.
7. Practitioners must facilitate parents' relationships with other parents and community members, as well as access to community resources and supports.
8. Practitioners must combine an understanding of individual and family strengths with a sensitivity to a family's needs, as well as to the challenges or adversity they may face.

Cultural Competence and Humility

Strengthening Families was developed as an approach that would enable unique implementation in different service settings and would be applicable across diverse cultural populations. Given the racial, cultural, and linguistic diversity in the United States today, the Strengthening Families approach emphasizes the importance of child and family service providers demonstrating both cultural competence and cultural humility in the design and implementation of their policies, programs, and practices.

Cultural competence is defined as learning about and respecting other people's culturally based goals, values, beliefs, behaviors, and practices (Lubell et al. 2008; Waters and Asbill 2013). Cultural humility, on the other hand, involves an active reflection and critical consciousness of one's own assumptions, beliefs, and values about racial and cultural differences that may influence one's perception and treatment of children and parents (Tervalon and Murray-Garcia 1998). Engaging in cultural competence and cultural humility are ongoing processes that recognize, value, and appreciate the richness of cultural diversity, and acknowledge one's willingness self-examine and self-critique in order to continue to grow and learn (Tervalon and Murray-Garcia 1998; Waters and Asbill 2013).

Hall (1976) conceived culture as comprised of both surface structure elements (e.g., a group's traditions and style of dance) and deep structure elements (e.g., a group's worldview and values). Given this definition, the five Strengthening Families protective factors are regarded as universal—in that they are conceived as essential for all families to thrive—yet may be understood (deep structure) and manifest (surface structure) in culturally specific ways. Thus, in order to respectfully help parents to build their protective factors, child and family service providers should (a) have parents themselves acknowledge how the protective factors are understood and manifest from their cultural and family perspective, and (b) intentionally and conscientiously engage in cultural humility via self-reflection and reflective supervision (Harper Browne 2014).

Resilience Theory

The Strengthening Families approach grows out of resilience theory. Early studies of children who manifested healthy rather than pathological adaptation in the presence of risk factors conceived resilience as a personality trait that some children possessed and others did not (Anthony and Cohler 1987; Garmezy and Neuchterlein 1972). Numerous leading researchers today reject the notion of resilience as a personality trait and define it as an active process of positive adaptation in the face of hardship and adversity (Luthar 2003; Luthar and Cicchetti 2000; Walsh 2006). Walsh (2006) added that the outcome of demonstrating resilience is increased resourcefulness, positive transformation, and personal growth.

In addition, resilience is conceived as contextual rather than as absolute. That is, individuals may demonstrate adaptive behavior in response to negative experiences at one point in time or in one setting, but not at other times or in all settings (Masten and Powell 2003). The contextual aspect of resilience also means that it is important to consider the cultural, social, political, and ideological factors contributing to resilient adaptation in order to implement more culturally responsive intervention strategies aimed at fostering resilience (Fraser et al. 2004; Luthar and Cicchetti 2000; Ungar 2005; Wright and Masten 2006).

The Strengthening Families Protective Factors

Numerous studies have found that poor child outcomes (e.g., low academic performance, hypersensitivity to stressors, depression, and social adjustment difficulties) are correlated with various risk factors such as poverty, maternal depression, community violence, family conflict, and parental substance abuse (Fagan et al. 2007; Garbarino et al. 2004; Gilbert 2004; Hammen 2003). The Centers for Disease Control and Prevention (2009) reported that, in addition to addressing risk factors, better child outcomes might be achieved by also enhancing protective factors that

help children avoid or mitigate the impact of risk factors associated with adverse health, behavioral, and educational outcomes.

Typically, protective factors are conceived only in relation to risk factors, that is, as conditions that reduce the impact of risk factors. The Strengthening Families approach, however, asserts that healthy developmental and well-being outcomes cannot be achieved simply by preventing, mitigating, coping with, or eliminating risk factors. Within the Strengthening Families approach, protective factors are defined as attributes or conditions that simultaneously (a) prevent or mitigate the effect of exposure to risk factors and stressful life events, and (b) build family strengths and a family environment that promotes optimal child development (Harper Browne 2014). The Strengthening Families approach emphasizes the cumulative nature of the five protective factors. Turner et al. (2007) stated that although independent protective factors can be effective in buffering the effects of risk factors, research suggests that the presence of multiple protective factors can decrease the likelihood of involvement in problem behaviors.

In addition, the five protective factors are interrelated. For example, Keller and McDade (2000) found that the presence of parents' strong social support networks (social connections) can help to decrease the number and intensity of stressful events parents experience through the provision of timely, relevant assistance (concrete support in times of need), as well as facilitate effective coping with the demands of parenting (parental resilience), which in turn enables parents to provide essential nurturing attention to their children that promotes the development of secure attachments (social and emotional competence in children). Social connections also can be important sources of or links to parenting information (knowledge of parenting and child development). A brief description of the Strengthening Families protective factors follows.

Parental Resilience

Within the Strengthening Families approach, resilience—in general—is conceived as the process of managing stress and functioning well in a particular context when faced with adversity (Luthar 2003; Luthar and Cicchetti 2000). Resilience is learned through exposure to challenging life events facilitated by supportive relationships and environments; the outcome of demonstrating resilience is positive change and growth (Walsh 2006). More specifically, parental resilience is defined as the process of managing stress and functioning well when faced with general life or parenting-related stressors (Harper Browne 2014). Parents demonstrate resilience when they are able to call forth their inner strength to effectively manage daily life despite personal adversity, problems in relation to their child, or the challenging circumstances of their family. Thus, it is important to examine the nature and effect of stressors in relation to the parenting role.

Parenting Stress

Being a parent can be a very happy and rewarding experience. However, when parents are faced with events or conditions that they perceive as difficult to manage, they can experience "parenting stress," that is, negative psychological and physiological reactions such as depression and migraine headaches. Stress in the parenting system during the first three years of a child's life can negatively impact the child's emotional development and behavioral responses, as well as the emerging parent–child relationship (Abidin 1995). Also, stress in the parenting system is a risk factor for child abuse and neglect (DiLauro 2004; Sprang et al. 2005).

Parenting stress can be caused by *general life stressors*—such as a poor marital relationship, the death of a loved one, or discrimination—or *parenting stressors*—such as not being able to soothe a crying baby, feeling overwhelmed by a child's needs, or lack of social support (Cronin et al. 2015; Deater-Deckard 2004). Parents vary widely in their perception of events or conditions as stressful, depending on factors within the parent, the physical environment, or the social structure (Cronin et al. 2015). For example, factors such as racism and persistent social inequities can pose a constant background level of threat for ethnic minority parents and children (Tolan et al. 2004), but ethnic majority family members may not perceive these factors as relevant to, or sources of stress in, their lives.

Parenting stress can be a consequence of a parent's early history. Intense, prolonged, traumatic experiences in childhood can impact physical, social, emotional, and cognitive development through adolescence and into adulthood (Shonkoff et al. 2012). As a result, parents with childhood trauma histories may display symptoms of anxiety or depression which can lead to poor parenting behaviors (e.g., indifferent, inconsistent, or harsh caregiving), and place children at increased risk of insecure attachments and other negative outcomes (Center on the Developing Child at Harvard University 2009, 2010; National Scientific Council on the Developing Child 2004a), which can further exacerbate parenting stress (Cronin et al. 2015). Thus, parenting stress creates a vicious cycle that adversely affects the parent and their child.

Facilitating Parental Resilience

Exposure to general life, parenting, or traumatic stressors are all potentially harmful to parents and their children, but this does not mean that negative parenting practices or negative outcomes for children are inevitable. For example, family economic hardship has been identified in numerous studies as a source of parenting stress (Aber et al. 2000; Duncan and Brooks-Gunn 2000; Puff and Renk 2014). Economic strain can increase parents' emotional distress, decrease their psychological resources (Raikes and Thompson 2005), and inhibit their ability to respond consistently, warmly, and sensitively to their child's needs (Cronin et al. 2015). However, Coleman and Karraker (2000), as well as Raikes and Thompson (2005),

found support for the hypothesis that family income alone does not determine the level of parenting stress. These studies revealed that social support and parents' sense of self-efficacy were protective factors that mitigate the impact of economic hardship on parenting stress.

Several strategies are recommended to help parents build resilience when they are living under stressful conditions or during difficult times (American Psychological Association 2015b; Beardslee et al. 2010). These include providing opportunities and environments that help parents to:

- Identify and mobilize their strengths and existing resources
- Nurture a positive sense of self
- Find meaning and a sense of purpose in their lives
- Reflect on their current conditions and visualize new possibilities for themselves and their children
- Accept circumstances that cannot be changed and concentrate on those that can
- Develop and maintain optimism and a belief that, while change may take time, problems are not insurmountable
- Identify specific needs or problems
- Set reasonable goals
- Take appropriate, decisive steps toward solving problems and reaching goals
- Acknowledge their own needs and feelings and engage in self-care
- Forge positive relationships with caring, supportive people

All parents experience stress from time to time. Thus, parental resilience is a key process that all parents need in order to effectively manage stressful situations and help ensure that they and their children are on a trajectory of healthy, positive outcomes. Building resilience increases parents' self-efficacy because they are able to see evidence of their ability to face challenges, to make wise choices about addressing challenges, and feel more in control of what happens to them (Raikes and Thompson 2005).

Social Connections

The Strengthening Families approach defines social connections as parents' healthy, sustained relationships with people, institutions, the community, and a force greater than oneself that promote a sense of trust, belonging, and that one matters (Harper Browne 2014).

Providing opportunities and experiences that enable parents to forge sustainable and positive social connections is critically important, but alone is not sufficient. What is essential is that the social connections engender a sense of connectedness, that is, a sense of belonging, attachment, reciprocal positive regard, and that one matters (Whitlock 2004). The lack of a sense of connectedness results in feelings of social isolation. Numerous studies have found social isolation to be a risk factor for child abuse and neglect and to be related to many adverse outcomes for children and families (Garbarino 1982).

Parents need people who care about them and their children unconditionally; who can be non-judgmental listeners; who they can turn to for well-informed advice; who they can call on for help in times of need; who help fulfill their need for affiliation and social stimulation; who can provide encouragement and hope when they need it; and who can affirm their healthy parenting efforts. In their review of the literature, Ozbay et al. (2007) reported that numerous studies have demonstrated the protective effects of having available and supportive social connections on physical and psychological health, and the negative consequences of poor social connections. Positive, strong social connections have been found to be particularly important when parents are faced with stressors because positive, strong social connections tend to mitigate the negative effects of stress on individuals' well-being, which increases the likelihood of effective parenting behaviors and an enriched environment for children (Beeber and Canuso 2012; Marra et al. 2009).

Parents also need to be constructively engaged in social institutions and environments, such as religious communities, volunteer opportunities, or their child's early education program. Involvement in social institutions provides opportunities for parents to participate in organized activities and to find meaning in contributing to the well-being of others, their community, or the larger society (Jordan 2006). Giving of oneself implicitly assigns value to the giver and positively contributes to one's sense of self-worth.

In addition, the Strengthening Families approach emphasizes the importance of spiritual connectedness in the lives of parents. In this context, spiritual connectedness is defined as "viewing life in new and better ways, adopting some conception as transcendent or of great value, and defining oneself and one's relation to others in a manner that goes beyond provincialism or materialism to express authentic concerns about others" (Reich et al. 1999 cited in Lerner et al. 2005, p. 60). A sense of spiritual connectedness can be a source of strength for parents, promote hope and optimism, and help parents to find meaning and a positive purpose in their lives (McEvoy et al. 2005).

Positive, constructive, supportive, social connections that create a sense of connectedness enable parents to experience meaningful interactions that help buffer them from, or mediate the impact of, general life and parenting stressors. High quality social connections support nurturing parenting behaviors that promote secure attachments and other positive outcomes in young children. Therefore, parents' protective social connections are beneficial to both the adults and the children in the family.

Parent–Child Connectedness

Parent–child connectedness is regarded as a bidirectional, high quality emotional bond between a parent and child which is sustained over time (Lezin et al. 2004).

The high quality nature of the emotional bond contributes to parent–child interactions that are pleasant and that serve as buffers from various stressors. Although the specific environments and experiences that promote parent–child connectedness are different across developmental periods, Rolleri et al. (2006) identified seven key parent behaviors that are essential for establishing, maintaining, and increasing parent–child connectedness, irrespective of the child's age, specifically: (a) providing the basic physiological needs; (b) building and maintaining trust; (c) demonstrating love, care, and affection; (d) sharing activities with children; (e) preventing, negotiating, and resolving family conflicts; (f) establishing and maintaining structure; and (g) communicating effectively. The National Scientific Council on the Developing Child (2004a) reported that young children whose experiences forge parent–child connectedness are more likely to have cooperative interactions with peers and other adults, develop empathy, and have stronger cognitive skills.

Unfortunately, many children's family environments and life circumstances do not promote parent–child connectedness and social–emotional competence. That is, many children are in environments that are unsafe, unstable, unstimulating, language poor, or sources of toxic stress; or their care that is inconsistent, unresponsive, abusive, neglectful, or rejecting. A growing body of research has shown that these types of early adverse environments and experiences place young children at risk for limited language and cognitive skills, difficulties interacting effectively with their peers, insecure attachments, developmental delays, behavioral and mental health problems, and an array of health problems and conditions later in life, such as lung disease, cancer, depression, and alcoholism (Center on the Developing Child at Harvard University 2010, 2011, n.d.; Felitti 2002; Stark and Chazan-Cohen 2012).

Knowledge of Parenting and Child Development

The Strengthening Families approach emphasizes that all parents, and those who work with children, can benefit from increasing their knowledge and understanding of the science of early childhood development. Increased knowledge enables adults to develop and apply strategies that emerge from current research into their day-to-day interactions with young children and to develop programs and policies that are designed to help young children flourish in all developmental domains—physical, cognitive, language, social, and emotional. The Strengthening Families approach regards certain knowledge areas as essential for promoting healthy child development and well-being, including (a) factors that promote or inhibit healthy child outcomes; (b) positive approaches to responding to appropriate and inappropriate child behavior; (c) signs indicating a child may have a developmental delay and needs special help, resources, and supports; and (d) cultural factors that influence parenting practices and the perception of children (Harper Browne 2014).

Knowledge of recent advances in the fields of neuroscience and developmental psychology is of particular relevance for parents and those who work with children.

Scientists in these fields understand more about early brain development and how its course impacts development, behavior, and health across the life span. For example, an abundance of research has demonstrated that developing brains need attuned, emotionally available and responsive parents and other primary caregivers who recognize and consistently attend to the needs of young children, and interact with them in an affectionate, sensitive, responsive, and nurturing manner (Center on the Developing Child at Harvard University 2010; National Scientific Council on the Developing Child 2004a). Conversely, if adult–child relationships are inconsistent, inappropriate, or absent altogether, the brain's architecture may fail to fully develop the neural connections and pathways that facilitate later learning, development, and behavior (Shonkoff and Richmond 2009).

Understanding the growing evidence about the nature and importance of early brain development provides parents and early childhood educators with insight about what young children need in order to thrive and succeed in school and in life, in particular:

- Available, nurturing, reliable, and trusting adults who consistently respond to and meet the needs of the child
- Regular, predictable, and consistent routines and environments
- Safe and secure physical and social environments that provide protection from physical and psychological harm
- Interactive language experiences
- Opportunities to explore and to learn by doing and repeating activities

Although the Strengthening Families approach identifies specific topics as essential knowledge areas for all parents and those who work with children, this approach also emphasizes that what is considered to be effective parenting and socialization of children is contextual, particularly with respect to culture and family circumstances. Spicer (2010) found that culture influences parenting goals, expectations, rules, responses to difficult behavior, and the manner in which children are encouraged and positively reinforced. Similarly, what constitutes effective parenting also depends on the social context and environmental circumstances. For example, it may be critically important for parents to be controlling, place a high value on obedience, and limit social involvement with peers in an effort to protect children from potentially dangerous neighborhood influences (Tolan et al. 2004). Thus, considering parents' culture and family circumstances is important in efforts to effectively engage parents in knowledge development, and to have those who work with children to implement developmentally and contextually appropriate best practices.

Social and Emotional Competence of Children

The Strengthening Families approach incorporates the current consistent finding that acquiring social and emotional competence is the primary developmental task of early childhood. In the past, researchers and practitioners focused on building young

children's academic skills in an effort to ensure they were prepared for school. However, in recent years a growing body of research has demonstrated the strong link between young children's social–emotional competence and their cognitive development, language skills, mental health, identity development, communication skills, social skills, and school success (The Annie E. Casey Foundation 2013; National Scientific Council on the Developing Child 2004b; Raver 2002).

In early childhood, developing social–emotional competence includes learning to understand one's own feelings and express them in a constructive manner; regulate one's behavior; accurately read and understand others' feelings; and form close and secure adult and peer relationships (Center on the Developing Child at Harvard University 2011; National Scientific Council on the Developing Child 2004b). Two major components of social and emotional competence that are highlighted in the Strengthening Families approach are self-regulation and executive functions. Self-regulation incorporates two components: (a) the control and coordination of thoughts, emotions, and behaviors, and (b) the ability to adapt behavior in order to achieve a goal. Executive functions are interrelated processes (e.g., persistence, personal agency, ignoring distractions, controlling impulses, inhibition) that contribute to self-regulation and influence cognitive processes and social–emotional behaviors (Carlson 2005; Center on the Developing Child at Harvard University 2011).

Neuroscience research has shown that the development of self-regulation and executive functions in early childhood are linked to early brain development and must be actively practiced at home and in preschool in order for various areas in the brain to be fully developed and reinforced (Center on the Developing Child at Harvard University 2011). Self-regulation and executive functions are considered to be essential for school readiness and academic achievement because they help children control their attention and behavior and are fundamental tools for learning (Masten et al. 2008). In addition, developing strong social–emotional competence will enable children to be better prepared to manage stress and persevere through adverse circumstances as adults (National Scientific Council on the Developing Child 2004b).

The components of social–emotional competence do not evolve naturally. The type and quality of experiences parents and other caregivers provide for young children can either strengthen or undermine the development of social–emotional competence (Shonkoff 2013). Research findings indicate that a relationship with a consistent, caring, and attuned adult who provides experiences that support social–emotional development—such as creating an environment in which children feel safe to express their emotions—is essential for healthy social–emotional outcomes in young children (Center on the Developing Child at Harvard University 2011, n.d.). Children who have such experiences are able to recognize their and others' emotions, take the perspective of others, and use their emerging cognitive skills to think about appropriate and inappropriate ways of acting. Conversely, children who do not have these experiences may not be able to feel remorse or show empathy, have limited language and cognitive skills, and have a difficult time interacting effectively with their peers (National Scientific Council on the Developing Child 2004b).

Shonkoff (2013) and Stark and Chazan-Cohen (2012) stated that in order to provide experiences that promote self-regulation and executive functions, parents and other caregivers must have these skills themselves. Adults who experienced nurturing, emotionally available caregivers are better equipped to be attuned and responsive to their own children or the children they work with. In contrast, adults whose social–emotional skills are not well developed need experiences that will cultivate their own social and emotional competence in order to enhance their ability to model and build these skills in children (Center on the Developing Child at Harvard University, n.d.). This finding exemplifies the need for two-generation approaches that promote the healthy development of young children by developing the capabilities and resources of the adults in their lives. "Because young children's emotional well-being is tied so closely to the mental health of their parents and non-family caregivers, (their) emotional and behavioral needs are best met through coordinated services that focus on their full environment of relationships" (National Scientific Council on the Developing Child 2012, p. 7).

Concrete Support in Times of Need

The Strengthening Families approach acknowledges that all parents need help sometimes. Whether they are faced with very trying circumstances—such as losing a job, home foreclosure, substance abuse, not being able to feed their family, or trauma—or less challenging situations, all parents need access to concrete support that addresses their particular needs and helps to minimize the stress caused by challenges and adversity. Parents' concrete supports may be informal or formal sources of help for themselves and their children. Informal sources include people who are a part of the parents' personal social connections, such as family members, friends, neighbors, co-workers, and members of one's faith-based community. Formal sources include people attached to organizations or agencies that provide a service to parents, children, and families, such as a pediatrician, school psychologist, mental health counselor, or case manager (Harper Browne 2014).

Within the Strengthening Families approach, concrete support in times of need underscores the importance of (a) encouraging parents to seek, identify, access, and advocate for needed help, and (b) providing parents with a quality of service designed to preserve their dignity and promote healthy development. Even though parents may need informal or formal help, they may not seek it. Several variables have been identified as causes of parents' reluctance to seek help (Boulter and Rickwood 2013; Dempster et al. 2013; Girio-Herrera et al. 2013; Keller and McDade 2000):

- Perceiving help-seeking as a sign of personal inadequacy
- Feeling embarrassed because the services they or their children need have a stigma associated with them (e.g., special education programs, domestic violence shelters)
- Preferring to seek help from informal sources rather than formal sources

- Poor past treatment in formal or institutional settings
- Lack of trust toward those who may be in a position of authority
- Difficult past experience trying to matriculate through the process of getting services
- Limited awareness of and ability to recognize children's problem symptoms or behaviors
- Fear that their child may be removed from the family if a problem is identified
- Lack of awareness of relevant available services
- Lack of available and accessible resources and services

Given these variables, it is important for child- and parent-serving programs to provide guidance to parents about their rights in accessing services and about navigating the complex web of medical, mental health, human services, and social services systems. These experiences may counter some parents' reluctance to seek help and contribute to their understanding that seeking help is not an indicator of weakness or failure as a parent. Rather, parents may realize that seeking help is a step toward improving one's circumstances, learning to better manage stress and function well, and developing self-advocacy skills. When parents have self-advocacy skills they are able to identify and describe their strengths and needs, as well as the desired concrete supports that address their needs (Harper Browne 2014).

It is also essential for child- and parent-serving programs to reflect on attitudes and practices displayed in their programs that may be contributing to parents' reluctance to seek help. Keller and McDade (2000) emphasized that service providers need to make intentional efforts to reestablish trust with parents in a manner that makes them feel valued. In addition, access to concrete support in times of need should be accompanied by a quality of service coordination and delivery that is respectful, culturally responsive, supportive, and is designed to preserve parents' dignity and to promote their and their family's healthy development. Two delivery strategies are emphasized: strengths-based practice and trauma-informed care.

Using a strengths-based approach in working with parents is advised because it: (a) regards parents as knowledgeable and competent; (b) encourages continuous parent and child growth and competency building; and (c) promotes shared decision making between parents and program staff (American Academy of Pediatrics 2013). A strengths-based approach helps parents feel valued and develop a sense of self-confidence and self-efficacy because they have opportunities to build their skills, experience success, and provide help to others when needed (American Academy of Pediatrics 2013; Grant and Cadell 2009; Saint-Jacques et al. 2009).

The Strengthening Families approach also recommends the provision of trauma-informed care in the delivery of concrete support in times of need. A trauma-informed workforce is: (a) cognizant of the child's and parent's trauma histories; (b) knowledgeable about the connection between those histories and the family's current functioning and behavior; (c) knowledgeable about and skilled in evidence-based trauma-informed care and trauma-focused services; and (d) changes the paradigm from one that asks, "What's wrong with you?" to one that asks, "What

has happened to you?" (Klain and White 2013; National Center for Trauma-Informed Care 2012; Taylor and Siegfried 2005). Overall, helping parents to identify, find, and receive concrete support in times of need in an effective and productive manner, helps to ensure they and their children receive the basic survival necessities everyone deserves in order to grow and thrive, as well as specialized health, mental health, social, legal, educational, or employment services (Harper Browne 2014).

Conclusion

The original hypothesis of the Strengthening Families approach was that staff of early care and education programs could play a more intentional, active role in the prevention of child maltreatment, beyond their legal obligation to report abuse or neglect when it is observed or suspected. Thus, the approach was originally called "Strengthening Families through Early Care and Education." During the 13 years since its introduction, the Strengthening Families approach has branched out from daily practice in early childhood programs and has been integrated into health care and human services system (e.g., child welfare), public policy (e.g., Quality Rating and Improvement Systems), and early intervention programs (e.g., home visiting). In addition, several jurisdictions have integrated Strengthening Families into policy and practice as an approach and framework for promoting healthy family life, in general, and not singularly as an approach for addressing for child maltreatment prevention. Consequently, the tagline "Through Early Care and Education" has been replaced with "A Protective Factors Framework" to acknowledge the shift to a more comprehensive approach with a focus on stronger families and child well-being.

The Strengthening Families Approach and Protective Factors Framework exemplifies CSSP's commitment to identify, communicate, and apply research-informed ideas that contribute to improved outcomes for children, youth, and families. Parents, system administrators, program developers, service providers, and policy makers can benefit from learning about and using the Strengthening Families Approach and Protective Factors Framework in their efforts to ensure parents and children are on a path that leads to healthy development and well-being.

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Parent- and Community-focused Approaches to Supporting Parents of Young Children: The Family Networks Project

Cheri J. Shapiro

Parents and primary caregivers are the most important individuals influencing the development of young children. Growing recognition of the importance of nurturing environments to the health and well-being of children and families (Biglan et al. 2012) underscores the need to promote and support parents, who create the most proximal environment for nurturing children's growth and development. Enhanced caring and protection within families, and reduction in adverse events such as child maltreatment, have the potential to have long-term impact on child development, health, and functioning, extending into adulthood (Shonkoff et al. 2012). Parenting supports and interventions that assist parents in engaging responsively and warmly with their children, encouraging positive daily interactions, establishing and maintaining safety, and providing structure and limits in a non-coercive manner are particularly important. Such warm, nurturing home environments foster healthy child development. Nurturing environments also offer protection to young children from the negative biological, developmental, psychosocial, and health impacts of prolonged (toxic) stress caused by adverse circumstances and can promote healthier brain development and enhanced physical and mental well-being (Shonkoff et al. 2012).

Importantly, no one type of parenting support can meet the needs of all parents. The type of support needed varies based on the specific needs and desires of parents and primary caregivers, as well as the developmental level and needs of the child. Extant parenting interventions and supports vary widely and can target a range of outcomes including the quality of the parent–child relationship, parenting skills, parenting self-efficacy, child behavior, literacy, or school readiness (among others).

C.J. Shapiro (✉)
Institute for Families in Society, College of Social Work,
University of South Carolina, Columbia, SC, USA
e-mail: cshapiro@mailbox.sc.edu

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Given the wide range of purposes that parenting supports and interventions can serve, it should not be surprising that parenting services are provided by a host of individuals embedded in a variety of organizations from many different professional and paraprofessional backgrounds. While this array of providers and settings sets the stage for parents to potentially obtain support in a number of settings that they encounter in daily life, such as childcare centers or health clinics, it also means that parent support and intervention services can be fragmented and difficult to implement in a systematic way. The fact that no single program can meet the needs of all parents and young children also creates significant challenges for implementation and evaluation of large-scale parent supports.

While all parents can benefit from some type of support, either formal or informal, parents of young children, here defined as children below age 5, warrant particular attention. The prenatal period through the first five years of life sets the stage for development over a lifetime. The critical nature of this early period to healthy child development has been clearly established (e.g., Shonkoff 2003). Effective care in the early years provides the foundation for a child's future social, emotional, and behavioral functioning, as well as health outcomes in adulthood (Shonkoff 2010; Shonkoff et al. 2012). Because of the importance of the 0–5 age range, extant models of pediatric practice recommend frequent contact with caretakers and children during the age range of 0–5 years in order to provide necessary anticipatory guidance and support (see Chapter "Promoting Early Child Development in the Pediatric Medical Home", this volume). The need for supporting parents of young children is made even more clear when one considers that rates of child maltreatment are highest in the 0–5 age range ("Child Maltreatment: Facts at a Glance—childmaltreatment-facts-at-a-glance.pdf," n.d.).

Support for parents of young children takes many forms, ranging from anticipatory guidance to help parents understand children's growth and development to more intensive interventions for children who may be experiencing social, emotional, or behavioral challenges. Under certain circumstances, however, specialized supports are likely to be needed. Parents of young children with disabilities may require support beyond that needed for typically developing children. Additional or specialized supports may be needed because children with disabilities are at higher risk for developing behavior problems than are typically developing children (Handen and Gilchrist 2006; Ozonoff et al. (2007), especially those with fair or poor health or communication difficulties (Emerson and Einfeld 2010). Youth with autism spectrum disorder (ASD) as well as intellectual disabilities are at higher risk for hyperactivity, conduct, and emotional problems (Totsika et al. 2011). The connection between disabilities and behavior problems has been noted for children as young as age two and can be stable across time (Baker et al. 2002; Herring et al. 2006). Problem behaviors that are present in typically developing children can occur with greater severity, frequency, or duration among children with developmental disabilities (Sanders et al. 2003a). Such problem behaviors can negatively impact the child, their family, and the community by increasing parent stress, disrupting parent–child relationships, contributing to family isolation, and to possibly place children at higher risk for maltreatment (Sanders et al. 2003a). Indeed,

studies have documented links between child maltreatment and disabilities (Sullivan 2009; Sullivan and Knutson 2000). Young children with disabilities may be at greater risk for maltreatment than typically developing young children because of the increased rates of child behavior problems, parental stress, and social isolation that may be found in this population. While early intervention efforts have demonstrated positive impact on a range of developmental outcomes for youth with developmental delays (Love et al. 2005; Mercy and Saul 2009), the extent and degree to which these efforts can improve parenting and family functioning, thereby decreasing the risk for later maltreatment, is not known.

Given the importance of supporting parents of both typically developing young children as well as parents of young children with disabilities, this chapter begins with a brief overview of several examples of current evidence-based approaches for supporting parents and primary caregivers of children below age 5 that focus on parents as the agents of change. The approaches included here have been selected as illustrative examples of the power and potential of interventions designed specifically to support parents and caregivers of young children. These interventions have all clearly demonstrated empirical evidence of impact on important outcome domains for children and parents and are included on at least one nationally recognized list of evidence-based programs and practices (e.g., National Registry of Evidence-based Programs and Practices, California Evidence-Based Clearinghouse for Child Welfare). However, because parenting interventions alone may not be sufficient to address the many needs of parents of young children with disabilities, the remainder of the chapter describes the Family Networks Project, a collaborative intervention designed to support and strengthen protective factors in parents of very young children with disabilities. Results of two randomized trials examining the impact of the project will be presented. The concluding portion of the chapter identifies potential future directions for helping support families with young children through parenting supports and interventions.

Current Evidence-Based Approaches for Supporting Parents of Young Children

Nurse Family Partnership

Perhaps the most optimal time to provide support for parents is during the prenatal and early childhood period, given the importance of early development and supportive environments to later functioning. Supporting positive development of both mothers and children also can prevent of a wide variety of maladaptive outcomes, including child maltreatment and involvement in the criminal justice system. Designed specifically for low-income first-time mothers, the Nurse Family Partnership (NFP) program provides mothers' support from pregnancy until the children turn two years of age (see www.nursefamilypartnership.org/). Mothers are

enrolled through the end of the second trimester of pregnancy and receive services until the child's second birthday. The intervention focuses on improving prenatal health, preventing child maltreatment and behavioral dysregulation, as well as improving family functioning and economic self-sufficiency in the first two years of life (Olds 2008, pp. 2–3). The initial intervention targets are improving maternal prenatal health. Post-delivery intervention targets include increasing maternal caregiving skills to promote child health and development as well as promoting future family stability through educational and work goal setting.

NFP services are delivered in client homes by nurses using a reflective model of practice (Beam et al. 2010). The NFP National Service Office works with organizations and communities interested in implementing NFP. Interested agencies/communities must be able to serve 100 families. Standard delivery is 8 nurse home visitors serving 25 families each (see http://www.nursefamilypartnership.org/communities/local-implementing-agencies). Research has supported significant short-term benefits, including improved maternal health, increases in responsive parent–child interactions, reduced injuries and emergency room visits, and reductions in child maltreatment (Olds 2006, 2007, 2008). Long-term impacts include reductions in maltreatment as well as youth involvement in the juvenile justice system (Olds 2007). Program impact appears to be greatest for those families at greatest risk (Olds 2007).

Parent–Child Interaction Therapy

Encouraging children's social, emotional, and behavioral skills, especially when child behavioral challenges are present, can involve a specific focus on the parent–child relationship. This approach is the core of parent–child interaction therapy (PCIT). PCIT is designed for parents of children ages 2–7 with externalizing behavior challenges (e.g., aggression, defiance; see http://www.cebc4cw.org/program/parent-child-interaction-therapy/detailed for a complete overview).

PCIT is grounded in attachment, social learning, and parenting approaches, and, in contrast to standard behavioral parent training models, focuses on modifying the interaction between parents and children (Foote et al. 1998). Thus, both parents and their children participate in the intervention, an approach designed and particularly well suited for parents of young children. An additional distinguishing feature is the use of live, in-session coaching by the therapist to support parent mastery of skills. Parents receive direct coaching from the therapist to acquire the skills being taught, and each phase ends when parents demonstrate mastery of the requisite skills. The intervention consists of two major phases: child-directed intervention (CDI) and parent-directed intervention (PDI). CDI uses a client-centered model of play; within this context, parents are taught skills to attend to their children and encourage appropriate talk and play. The primary goal of this phase is to strengthen the relationship between parents and children. During the PDI phase, parents are taught non-coercive strategies for increasing compliance and managing misbehavior.

PCIT is typically delivered in clinic settings; however, recent research has examined delivery in other settings (e.g., primary care, Berkovits et al. 2010) or via Internet videoconferencing methods (Comer et al. 2015). The length of the intervention is determined by parent attainment of specific competencies and not on a fixed number of sessions. Thus, delivery for a specific family can vary but averages at approximately 14 weeks. Recent research has examined two brief versions of PCIT using a randomized design; while between-group differences were not found, this type of adaptation has the potential to broaden reach of the intervention (Berkovits et al. 2010). PCIT has also been examined with parents of young children with disabilities or developmental delays. Improvements have been noted for parents and young children (ages 3–6) with intellectual disabilities and oppositional defiant disorder (Bagner and Eyberg 2007). PCIT has also demonstrated positive impact for mothers of young children born prematurely; significant decreases in child behavior problems were noted and the mothers were observed to be more positive in child-led play compared with mothers of similar children in a waitlist control group (Bagner et al. 2010). PCIT outcomes include improvements in parent–child interactions and reductions in child behavior problems and parenting stress (Eyberg et al. 2001); intervention gains can be maintained over time, especially among families who complete the intervention (Boggs et al. 2004; Hood and Eyberg 2003).

Incredible Years

Incredible Years (IY) is a multifaceted approach designed to increase children's social competence and prevent and treat conduct problems in children that includes parent-, child-, and teacher-directed interventions (Webster-Stratton 2001). The rationale for this integrated approach is that IY targets a range of risk factors for the development of conduct problems and aims to strengthen protective factors that operate at multiple levels of the social ecology: parents, children, and the school environment (Webster-Stratton and Herman 2010).

IY interventions target parents and teachers working with children in the age range of 3–8 years, as well as children directly. IY interventions are delivered in a group format and can occur at a variety of community settings including clinics and schools. Of note, in addition to being evaluated with parents of typically developing children with disruptive behavior, IY has also been examined with parents of young children (ages 3–6) with developmental disabilities. The IY parent training group intervention was found to improve the behavior of preschool children with developmental disabilities (McIntyre 2008). IY has also been examined in a small study with two parents of young children with disabilities; an individual coaching model was used in addition to parent participation in an IY group (Barton and Lissman 2015).

Two primary parent training programs are available, the BASIC and ADVANCE programs; a SCHOOL AGE prevention parenting program is also available. The

majority of research has focused on the BASIC and ADVANCE programs. The BASIC program lasts 12 weeks and teaches parents a variety of strategies to promote prosocial behaviors and to effectively manage misbehavior (Webster-Stratton 2001). The ADVANCE program supplements the BASIC program by addressing a range of additional parent and family risk factors for conduct problems such as depression, lack of support, and marital discord and also lasts 12 weeks (Webster-Stratton 2001). Outcomes for the parenting intervention include improved child behavior and child social and emotional competence or prosocial behavior, as well as improved parent–child interactions (Menting et al. 2013; Webster-Stratton 2001; Webster-Stratton et al. 2008). IY programs have also been demonstrated to be effective with low-income minority families (Reid et al. 2001). Initial feasibility of IY has been established for parents of children with developmental delays (McIntyre 2008), and application to parents of children with ADHD has been explored (Trillingsgaard et al. 2014).

The teacher training program also occurs in groups, delivered in group workshop format. The child program has two versions; one is a selective intervention delivered by classroom teachers and consisting of curriculum for children to enhance social, emotional, and behavioral functioning and is delivered in schools over a 18- to 22-week period (Webster-Stratton 2001). A second version of the child program is a 22-week small group therapeutic program that can be delivered in tandem with the parent program that targets skills including empathy, communication, and problem-solving skills, as well as anger management strategies (Webster-Stratton and Herman 2010). The teacher and child training programs have been demonstrated to positively impact teacher classroom management strategies and improved social and emotional functioning among young children when used as a universal prevention approach (Webster-Stratton et al. 2008).

Triple P-Positive Parenting Program

Triple P-Positive Parenting Program (Triple P) is a suite of parent-only interventions designed to improve parenting confidence and competence on a broad scale; this is the only parenting intervention intentionally designed from the outset as a public health approach to parenting (Sanders and Kirby 2014). Derived from behavioral family interventions, the intervention explicitly promotes parental self-sufficiency and independent problem-solving, which represents a unique approach to parenting interventions. Within Triple P, parents acquire effective parenting strategies within a self-regulatory framework designed to improve parental knowledge, skills, and confidence (Sanders 2012). Core Triple P interventions consist of five levels of increasing intensity and reach. When these core levels of the intervention are utilized as a system, it can be conceptualized as an approach to prevent or reduce child maltreatment through positive impact on family-based risk factors for maltreatment (Sanders et al. 2012).

Derived from behavioral family interventions, Triple P interventions focus on parents of typically developing children as well as children with disabilities ages 0-17. Core Triple P interventions consist of five levels of increasing intensity and reach. These include a universal media-based parenting information strategy (Level 1), Selected Triple P to provide advice about a specific parenting concern (Level 2), narrow-focus parent skills training (Level 3 Primary Care Triple P), broad-focus parent skills training (Level 4 Standard or Group Triple P), and more intensive behavioral family intervention (Level 5 Enhanced Triple P) (Sanders et al. 2002). Interventions occur in individual family, small group, and large group formats, depending on the level and type of Triple P used. Online delivery has been recently evaluated (Sanders et al. 2014).

Common outcomes from Triple P interventions include reductions in parent-reported child behavior problems, reductions in aversive parenting practices, and improvements in parental self-efficacy (Bor et al. 2002; Hoath and Sanders 2002; Sanders et al. 2000, 2003a). Several meta-analyses have documented the positive effects of *Triple P* (de Graaf et al. 2008a, b: Nowak and Heinrichs 2008; Sanders et al. 2014). Triple P interventions have been evaluated in multiple service delivery contexts (e.g., home, primary care, and online (Sanders et al. 2003b, 2012; Turner and Sanders 2006) with a wide variety of populations including toddlers/preschoolers, as well as children with conduct problems, attention deficit hyperactivity disorder, and developmental disabilities (Hoath and Sanders 2002; Roberts et al. 2006; Sanders et al. 2000). The strong evidence base, coupled with the availability of standardized program materials, manualized training procedures, and an infrastructure to support implementation, has resulted in widespread dissemination (Sanders 2012) and population-level trials (Prinz et al. 2009; Sanders et al. 2008; Zubrick et al. 2005).

Stepping Stones Triple P

One program variant of Triple P, known as Stepping Stones Triple P (SSTP), has been specifically designed and evaluated for parents of preadolescent children with disabilities (Roberts et al. 2006; Sanders et al. 2004). SSTP was developed to address the unique challenges experienced by parents of preadolescent children with developmental disabilities. Problem behaviors often noted in this population include poor social skills, aggression, or non-compliance.

SSTP has been evaluated in randomized controlled trials of young children with comorbid developmental disabilities and behavior problems, with parents of children with developmental disabilities only (Sofronoff et al. 2011), as well as with parents of young children of mixed disability types (Roux et al. 2013). SSTP can be delivered in a range of community settings including health or mental health care service settings, community settings, as well as in family homes. A recent meta-analysis of 12 SSTP studies found significant positive impact on child behavior and parenting outcomes; effect sizes for child behavior were medium;

effect sizes for parenting style were large but small for parent personal adjustment (Tellegen and Sanders 2013).

Need for Collaborative Interventions

As is evident from the empirical literature, evidence-based parenting interventions have demonstrated improvements in parenting behaviors, child behaviors, parent self-efficacy, and parent personal functioning in populations of both typically developing children and their parents as well as for parents of children with disabilities. Yet, it is important to acknowledge that parenting interventions alone may not be sufficient to optimize the long-term functioning of caregivers and children. This may be particularly true for young children with disabilities, who may require a range of services and supports to reach their full potential.

The Family Networks Project

The need to develop collaborative approaches that include evidence-based parenting interventions as part of a larger system of support lead to the development of the Family Networks Project (NFP). The FNP was designed to create and test the initial impact of a collaborative intervention designed to support and strengthen families with young children (below age 2) with developmental and other disabilities and to prevent negative outcomes including child maltreatment. Funded by the National Quality Improvement Center for Early Childhood (QIC-EC; Web site), the FNP was one of four research and demonstration projects each designed to develop innovative approaches for using a Strengthening Families framework (developed by the Center for the Study of Social Policy) to enhance protective factors and thereby prevent child maltreatment in children below age 2 (for information on the QIC-EC and each of the four projects, see the special issue published by the Journal of Zero to Three, Exploring New Paradigms for Evaluation and Service Delivery: The National Quality Improvement Center on Early Childhood, 2014, as well as Chapter "From Thought to Action: Bridging the Gap in Early Childhood for Our Most Vulnerable Children and Families", this volume).

The FNP project was made possible by the confluence of a number of factors, including interagency collaborations begun during the conduct of the U.S. Triple P System Population Trial, a population-level approach to child maltreatment prevention (Prinz et al. 2009; Shapiro et al. 2010). Representatives from state-level agencies and organizations responsible for school readiness, IDEA Part C services, child maltreatment prevention, early childhood systems, and a university conceptualized FNP as an avenue to extend the research and application of interventions to improve services and outcomes for families with young children with disabilities, specifically those children eligible for early intervention services through the

federally mandated Individuals with Disabilities Education Act, Part C (IDEA Part C) program.

The FNP had two primary goals. The first goal was to examine the potential role of Stepping Stones Triple P (SSTP; Sanders et al. 2003b, 2004) as an evidence-based parenting intervention in improving key protective factors for families of very young children (below age 2) with developmental and/or other disabilities who were eligible for IDEA Part C (early intervention) services. SSTP was conceptualized as a selective prevention approach, as children were not required to have behavior problems as a condition of project involvement; furthermore, no prior SSTP research had been conducted with parents of children this young. The version of SSTP selected for use was a 10-session individual family-based intervention implemented using a home-based model of service delivery given the goal of provision of supports in the natural environment. Level 4 Standard SSTP includes 10 sessions covering a wide range of strategies to promote positive relationships between parents and children, encourage positive behaviors, teach new skills, manage misbehavior, and ways to promote generalization of parenting skills (planned activity routines).

The FNP team acknowledged that a parenting intervention alone would likely be insufficient to increase protective factors and reduce the potential for child maltreatment. Thus, the second goal of the FNP was to consider the synergistic impact of SSTP along with an intervention designed to impact the community level of the social ecology. Specifically, the FNP aimed to support families further by enhancing the capability of individuals who interact regularly with families in the early intervention system, early intervention service coordinators, to build strong, supportive relationships with parents and thereby reduce risk for maltreatment.

Like early care and education professionals, early intervention service coordinators are in a strong position to develop trusting and supportive relationships with the families that they serve. However, many early interventionists may not have had specific training in family engagement or have a high degree of self-efficacy to engage with and support parents. Fortunately, self-efficacy is an important predictor of ability to engage and support parents, and exposure to in-service training can have a positive impact on practitioner self-efficacy (Dunst et al. 2014). However, no curriculum existed for professional in-service training of service coordinators in the area of supporting parent–child relationships and preventing maltreatment. To address this gap, an existing skills training approach, *Preventing Child Abuse and Neglect*: *Parent-Provider Partnerships in Child Care* (PCAN) was selected for use in the FNP. Created by Zero to Three, the PCAN curriculum was originally developed for early care and education professionals to enhance family-level protective factors and prevent child maltreatment (Seibel et al. 2006). In collaboration with key stakeholders from Zero to Three and members of the FNP team, informed by input from IDEA Part C service coordinators, the PCAN curriculum content was adapted for an early intervention workforce (see Kilburn and Shapiro 2015, for a complete description of the PCAN adaptation process and outcomes).

For the FNP, two separate randomized studies were conducted in two different regions of one southern state (see Shapiro et al. 2014). For both studies, families

were recruited through a range of referral sources including early intervention providers as well as via self-referral. To be eligible for either study, families had to have an infant between the ages of 11 and 23 months who was receiving early intervention services from an early intervention service coordinator who had agreed to be a part of the study (given the need to coordinate with and obtain information from the service coordinator). Families had to have no history of prior referrals for child abuse or neglect, be willing and able to participate in the study, have a telephone, and be open to receiving parenting intervention services in the home. Children whose severity of disability suggested a high likelihood of out-of-home placement during the time frame of the study (i.e., determined to be medically fragile per state guidelines) were not eligible for either study.

All families underwent assessments prior to study entry (baseline), five months after randomization, and at a 12-month follow-up point. Assessment instruments were selected to cover key domains of functioning including child behavioral functioning (Child Behavior Checklist 1.5–5; http://www.aseba.org), parenting style (Parenting Scale, Rhoades and O'Leary 2007), parenting confidence (Toddler Care Questionnaire, Gross and Rocissano 1988), parent personal functioning (Depression, Anxiety, Stress Scales, short form), parent–child relationship quality (Keys to Interactive Parenting Scale or KIPS, an observational measure; Comfort et al. 2011), relationship with service providers and, for families receiving the SSTP intervention, a client satisfaction measure.

For both studies, SSTP was delivered in family homes; no prior SSTP studies had examined the intervention using a home-based service delivery model. SSTP was delivered by community providers trained and accredited to deliver this intervention; all sessions were audiotaped to support assessment of fidelity and all providers had regular supervision by experts in Triple P interventions (see Shapiro et al. 2014 for additional details).

FNP Study One

The specific research question addressed in the first study was as follows: Will SSTP combined with IDEA Part C services as usual increase family strengths by improving parent and child functioning and parent–child relationships as compared to early intervention (IDEA Part C services) as usual? Thus, eligible families (n = 49) were randomly assigned to receive SSTP in addition to early intervention services as usual (n = 25), or early intervention services as usual (n = 24). The vast majority of the participants (96 %) were women, average age 30.94 years (SD = 8.2). A majority of the caregivers (63 %) were Caucasian, with 27 % African American, and 10 % "other." Forty-three percent described themselves as single. The majority (82 %) had an education of high school or beyond. Slightly less than half were in paid employment (45 %) and reported annual household incomes over $30,000 (49 %); 31 % reporting earning less than $20,000/year.

Assessments took place at baseline, post-treatment (5 months after baseline), and at 12-month follow-up.

A majority of the children (63 %) were boys with an average age of 19 months (SD = 3.37). Almost half (49 %) were Caucasian, with 25 % African American, and 25 % "other." Most (65 %) were eligible for IDEA Part C services because of developmental delay(s), and the other children were eligible due to a diagnosis increasing risk for current or future disability.

With regard to study outcomes, among the most important process results from this study were the level of attrition from the SSTP plus early intervention services as usual condition; 14 families received 5 or more SSTP sessions while only 12 families (48 %) completed all 10 sessions. This level of attrition was surprising given delivery of services in family homes. The majority of families that did not complete the intervention cited lack of time as the main reason for discontinuation.

Despite the low completion rate for the intervention, some trends were found in favor of the treatment group, especially in the areas of increased family strengths (in the form of fewer caregiver symptoms of depression), a more marked decrease in child behavior problems between post-treatment and 12-month follow-up for the treatment group only, and possibly decreased likelihood of child maltreatment (one family in the comparison group had a founded case of maltreatment during the course of the study but caution is warranted due to low base rate of maltreatment and small sample size in this study).

FNP Study Two

For the second FNP study, the impact of SSTP was assessed against a backdrop of the PCAN skills training approach implemented with IDEA Part C service coordinators. The specific research question addressed in Study Two was as follows: Will SSTP combined with IDEA Part C services enhanced by PCAN training increase family strengths by improving parent and child functioning and parent–child relationships as compared to IDEA Part C enhanced by PCAN training alone? In Study Two, a total of 40 families were eligible for the study; 20 were randomly assigned to the SSTP/PCAN enhanced services as usual condition and 20 were assigned to the PCAN enhanced services as usual condition. The sample consisted of 40 caregivers of a child with a disability. All of the participants were women, with an average age of 30.63 years (SD = 6.73); 37.5 % were single parents. The majority (90 %) had an education of high school or beyond. Slightly more than half (58 %) of the caregivers were Caucasian, with 35 % African American and 8 % "other." Forty-five percent were in paid employment, and half had annual household incomes over $30,000; 30 % reported earning $20,000/year or less.

Slightly more than half (58 %) of the children were boys. The mean age of the children was 19.9 months (SD = 3.34). Over half (55 %) were Caucasian, with 28 % African American and 18 % "other." Most (68 %) were eligible for IDEA

Part C services because of developmental delay(s), and the other children were eligible due to a diagnosis.

In contrast to the first study, far less attrition was found from the SSTP/PCAN condition in Study Two, with 16 of 20 families (80 %) completing the SSTP intervention. At the individual family level, findings from Study Two (in which there was little attrition from the intervention group) showed significant differences and trends in favor of the treatment group in the area of increased family strengths (reductions in permissive parenting practices and post-treatment impact on caregiver symptoms of depression), but other areas showed no significant results. Child functioning as assessed using the CBCL showed no significant treatment-comparison group differences at post-treatment or follow-up. However, in terms of parenting style, results indicated a trend toward significant treatment-comparison group difference favoring the treatment group at five months in terms of reduction in parental laxness (i.e., permissiveness); by the twelve-month follow-up time point, significant differences favoring the treatment group were evident in terms of parental laxness. Parents in the treatment group evidenced significant reductions in permissive parenting practices over time. In the area of parental personal functioning, a trend toward a significant difference was found between the treatment and comparison groups for depression symptoms at five months ($p = 0.078$) again favoring the treatment group. Other findings in the areas of parent personal functioning were not significant. Lastly, on an observational measure designed to assess the overall quality of the parent–child relationship, there was a trend toward relative improvement in this area for the intervention group as compared to the comparison group post-treatment ($t = 1.77$, $p = 0.082$) that was significant at the 12-month follow-up ($t = 2.33$, $p = 0.022$).

At the community level of the social ecology, the PCAN training as modified for an early intervention workforce was both feasible to deliver and positively received. Significant pre/post-changes in content knowledge were reported by the early intervention service providers who were trained. It is possible that PCAN training impacted retention in the SSTP intervention in this study as evidenced by the marked differences in attrition in this study as compared to Study One. One hypothesis is that PCAN training strengthened the parent-early intervention service provider relationship and that these early intervention providers supported parent continued participation in SSTP. However, any comparisons made between the two studies in this regard are tentative.

The findings of impact on laxness, a measure of permissive parenting practices, indicate that caregivers who learned and then implemented the SSTP strategies were able to implement appropriate and effective parenting strategies, avoiding lax and permissive practices. In terms of the significant difference in caregiver depression, the findings could be an indication that caregivers who learned and then implemented the SSTP strategies experienced less depression because of enhanced self-efficacy in managing their child's behavior; however, these differences were not maintained at follow-up. An important finding is the improvement in the quality of the parent–child relationship for the SSTP intervention group evident at the trend level at post-treatment but significant by follow-up. Changes in parenting practices

appear to have positively influenced the quality of the parent–child relationship that appeared to strengthen with the passage of time.

Summary of FNP

The FNP was designed to examine the potential impact of an evidence-based parenting intervention for parents of very young children with disabilities and to examine this impact as part of a collaborative intervention that included a workforce enhancement curriculum. The potential impact of SSTP on parent and child functioning in Study One was diminished by significant attrition from the intervention group; however, trends in outcomes for parent depression and possibly child behavior in the treatment group are suggestive that this is worth further exploration. The findings of Study Two are important and indicate the potential for SSTP to have an impact on parenting practices, parent functioning, and on the parent–child relationship when used as a selective preventive intervention.

Important lessons and considerations for future intervention research can be derived from the FNP. First, families cited lack of time was a significant factor contributing to the attrition noted from SSTP in Study One. This suggests that a brief intervention format may be more appealing to families with a child in the early intervention system, but this remains to be empirically examined. A second issue relates to how families perceive the need for interventions that focus on parenting skills and support. The FNP used a selective prevention model, providing intervention for parents of children who were at increased risk for the development of behavioral challenges, but who did not need to be demonstrating problems in this area in order to receive SSTP. Children in the FNP were under two years of age at project enrollment, further limiting the likelihood that they were exhibiting behavioral problems. Thus, the perceived need for receiving information on parenting strategies may have been low. A third issue relates to service delivery. Parents of young children with disabilities who are receiving early intervention services may have to contend with a number of specialized providers all working to support their children in different ways. Ideally, upskilling the existing workforce of early intervention providers to effectively deliver evidence-based parenting interventions may be the most efficient model. The feasibility, practicality, and impact of this approach await empirical examination.

Conclusions and Future Directions

Interventions that focus on parents as the agents of change offer tremendous promise to improve the lives of families with young children. The greatest benefit is likely to be achieved by providing support and, if necessary, intervention for families of very young children, and families of children who are at higher risk to

develop social, emotional, or behavioral problems. A number of evidence-based parenting interventions exist that have demonstrated both the power and promise of improving the lives of families with young children by helping caregivers promote child competencies, strengthen their parenting practices, improve their relationships with their children, and decrease the likelihood of maladaptive outcomes including child maltreatment. However, more work is needed, especially in the area of prevention and interventions for supporting parents of very young children with disabilities.

Important future directions include additional efficacy and effectiveness studies of current evidence-based parenting interventions with a wider range of children and families, including families of young children with disabilities, as well as examining multiple service delivery models. Consumer preferences need to be taken into account; research suggests that parents may prefer self-directed formats such as online intervention deliver over more traditional group or home-based models (Metzler et al. 2012). Modular approaches such as those created Chorpita and colleagues (Chorpita et al. 2013) as well as collaborative interventions that involve several types of interventions to support parents and improve family outcomes also need to be examined, especially with parents of children below age 5. Examination of interventions at multiple levels of the social ecology, that include pre-service and in-service training for professionals serving families with young children, is also needed. The continued high rates of social, emotional, and behavioral problems in youth and the significant impact these have on families, neighborhoods, and society demand ongoing efforts to support parents and caregivers in raising competent, happy, confident adults.

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Honoring Parenting Values, Expectations, and Approaches Across Cultures

Charlyn Harper Browne, Chrissie Castro and Panu Lucier

This chapter will address two essential components in developing culturally competent and effective supports for parents, specifically the importance of the following: (a) understanding and appreciating cultural differences and commonalities in parenting beliefs, values, expectations; and (b) encouraging providers to conscientiously engage in cultural humility. The worldview of American Indian and Alaska Native cultures, and the influence on parenting, will be highlighted.

Jerome Kagan, noted developmental psychologist, defined parenting as "implementing a series of decisions about the socialization of children" (Berns 2016, p. 125). Of course, not all parents make the same decisions. Belsky's (1984) work on the determinants of parenting proposed that the "series of decisions" are determined by (a) characteristics of the child, (b) the developmental history of the parents, and (c) the immediate and larger social contexts in which parents, the parent–child relationship, and the family evolves and functions. Similarly, the social–ecological perspective suggests that parenting is influenced by a complex interplay of individual factors (e.g., parent mental health, child characteristics); relational factors (e.g., marital conflict, social support); community factors (e.g., neighborhood resources, community violence), and societal factors (e.g., cultural norms, policies and laws that maintain inequities).

The social–ecological perspective suggests that in order to understand the determinants of parenting, it is necessary to examine the interaction between factors

C. Harper Browne (✉)
Center for the Study of Social Policy, Washington, DC, USA
e-mail: charlyn.harperbrowne@cssp.org

C. Castro
Los Angeles/City County Native American Indian Commission, Los Angeles, CA, USA
e-mail: chrissie.castro@gmail.com

P. Lucier
Crane Song Consulting, Anchorage, AK, USA
e-mail: plucier@usa.net

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at the different levels of the social ecology, as well as the influence of factors within a level. By highlighting American Indian and Alaska Native cultures, this chapter explores parenting as a cultural act; that is, the influence of culture on the series of decisions about the socialization of children.

Culture Defined

Although culture has many definitions, an overarching perspective describes culture as comprised of both observable surface structure elements—such as a group's music, traditions, and childrearing practices—and deep structure elements—such as a group's worldview, unique historical experiences, values, and beliefs (Hall 1976). It is the deep structure of culture that gives real meaning to the surface structure elements. Thus, the definition of culture guiding this discussion is "a set of values, beliefs, and ways of thinking about the world that influences everyday behavior" (Zepeda et al. 2006, p. 2).

Numerous research findings suggest that culture has a major influence on the following: (a) parents' beliefs, values, definitions (e.g., "good parenting"), expectations, and practices; (b) the behaviors parents consider to be appropriate and inappropriate; (c) the methods parents use to teach values and behaviors; and (d) parents' acceptance of and responsiveness to parenting messages from family, professionals, and media (Kim and Hong 2007; Lubell et al. 2008; Melendez 2005; Pinderhughes et al. 2000; Spicer 2010). Authentic and effective engagement with parents, then, requires a consideration of culture beyond an awareness of a family's unique dress, diet, and dance, to an understanding and appreciation of differences in values, significant historical influences, and belief systems.

Much of the research conducted in the USA about parent–child relationships, and the resulting recommendations about parenting practices, reflect White American ethnocentric beliefs and values about parents, children, and families (Cardona et al. 2000; Lubell et al. 2008). For example, Belsky (2014) acknowledged that "parenting that treats the child as an individual, respecting developmentally appropriate needs for autonomy, and which is not psychologically intrusive/manipulative or harshly coercive contributes to the development of the kinds of psychological and behavioral 'outcomes' valued in the western world" (p. 1). Van Campen and Russell (2010) asserted that, often, research studies "have been based on the assumption that the meaning of parenting is similar across cultures. Such thinking hides important differences in what cultures expect of and understand about parenting, [parent-child], and parent-adolescent relationships" (p. 1).

Such thinking also ignores or minimizes day-to-day concerns ethnic minority parents may have. For example, American Indian and Alaska Native parents often must take intentional steps to make sure their children see themselves, their family, and their culture represented in images in their early care and education settings. In contrast, ethnic majority parents tend to give little or no thought about how their

child will be taught or cared for, or whether their child will see themselves in classroom images, because it is presumed that the majority culture's core values and norms will be prevalent.

Thus, using a single cultural lens through which to communicate, assess, interact with, and make decisions about parents and families from diverse cultural groups is narrow in scope and increases the likelihood of interpersonal misunderstandings (Bornstein 2012; Greenfield et al. 2006), and difficulties in "the acceptance, delivery, and/or effectiveness of healthy parenting programs or interventions" (Lubell et al. 2008, p. 4). Also, using a single cultural lens implicitly suggests that there is a single human norm and that differences from that norm are tantamount to deviances and deficiencies.

Over the last decade, there is increasing interest in studying cultural differences in parenting without the presumption of a single parenting cultural norm. Bornstein (2012) pointed out that the differences in beliefs and behaviors found through cross-cultural studies may be normative in one cultural group and not necessarily normative in another cultural group. Nonetheless, cultural beliefs and practices are considered to be essential or advantageous to their respective group members. More specifically, Bornstein (2012) stated, "Culture helps to construct parents and parenting, and culture is maintained and transmitted by influencing parental cognitions that in turn are thought to shape parenting practices. Children's experiences with their parents within a cultural context consequently scaffold them to become culturally competent members of their society" (p. 212).

Cultural Competence and Cultural Humility

Given the increasing racial, ethnic/cultural, and linguistic diversity of the population in the USA, the early care and education field has acknowledged the importance of incorporating the concepts of cultural competence into its policies, programs, and practices in a meaningful way.

Cultural Competence

Waters and Asbill (2013) suggested that cultural competence should be regarded as a process rather than an outcome. Thus, cultural competence refers to the process of acquiring the knowledge and skills needed to interact effectively with diverse cultural groups. Within many professional fields, there has been a call for a culturally competent workforce, as well as programs and services that are designed to be respectful of families' cultures. "For the most part, program planners have responded to this concern by delivering services in a participant's primary language, matching participants and providers on the basis of race and ethnicity, and incorporating traditional childrearing practices into a program's curriculum" (Daro et al. 2009, p. 11).

For example, the National Association for the Education of Young Children (2009, pp. 1–2) delineated several recommendations for creating a culturally respectful environment and preparing early childhood professionals to work with diverse families and children, specifically:

1. Provide professional preparation and development in the areas of culture, language, and diversity.
2. Recruit and support educators who are trained in languages other than English.
3. Actively involve families in the early learning program.
4. Help all families realize the cognitive advantages of a child knowing more than one language and provide them with strategies to support, maintain, and preserve home language learning.
5. Convince families that their home's cultural values and norms are honored.
6. Ensure that children remain cognitively, linguistically, and emotionally connected to their home language and culture.
7. Encourage home language and literacy development, knowing that this contributes to children's ability to acquire English language proficiency.
8. Help develop essential concepts in children's first language and within cultural contexts that they understand.
9. Support and preserve home language usage.
10. Develop and provide alternative, creative strategies to promote all children's participation and learning.
11. Provide children with many ways of showing what they know and can do.

While acquiring information about culturally diverse and common parenting beliefs, values, and practices is important, and engaging in culturally sensitive activities is essential, alone these strategies are not sufficient. "From this perspective, competency involves more than gaining factual knowledge—it also includes our ongoing attitudes toward both our clients and ourselves" (Waters and Asbill 2013, para. 1). An approach that broadens the conceptualization of cultural competence is called "cultural humility."

Cultural Humility

Recommended strategies for working more effectively with diverse cultural groups have often neglected a focus on the worker's worldview; incorporating cultural humility in one's practice seeks to address this omission. Tervalon and Murray-Garcia (1998) defined cultural humility as a process of careful and ongoing self-reflection, self-critique, and critical consciousness about one's own embedded beliefs, values, worldview, stereotypes, and biases that may interfere with an effective encounter with others.

Cultural humility is grounded in the acknowledgment that there are limitations in acquiring knowledge about diverse cultural groups because it is impossible to know everything about another culture; individuals may be judging others based on their own

ethnocentric perceptions; and individuals may have unconscious negative beliefs about other cultures that can influence their work with and the perception and treatment of children and parents (Ortega and Coulborn Faller 2011). Practicing cultural humility enables individuals to do the following: (a) set aside their prejudices that may otherwise affect interactions with members of a different culture; (b) remain respectful of and learn from diverse others; (c) seek to understand others' worldview and any historical or contemporary sociopolitical experiences (e.g., racism, discrimination, oppression) that may be impacting their individual and cultural identities; and (d) develop a respectful attitude toward different points of view and behaviors (Ortega and Coulborn Faller 2011). Thus, acquiring information and reflecting on one's own assumptions about other cultures is essential in building and sustaining mutually respectful relationships with parents and families, as well as in developing policies and practices that impact various cultural groups. For example:

> The well-being of American Indian and Alaska Native (AI/AN) children and their families is directly connected to the relationship they have with their culture, extended families, and tribal communities. Federal and state child welfare policies and practices have sometimes not well understood or supported these relationships by not recognizing the unique qualities of AI/AN culture and the benefits of nurturing these relationships. (Simmons 2014, p. 1)

The next sections of this chapter describe how aspects of culture influence parenting in American Indian and Alaska Native families.

Overview of American Indian and Alaska Native Cultures

In this report, the Indigenous peoples of the continental USA are referred to as American Indian and Alaska Native cultural groups (AI/AN). There are over 500 federally recognized AI/AN tribes (Bureau of Indian Affairs 2015). Although many of these groups have their own distinct language, communication style, traditions, kinship structures, spiritual beliefs, and practices, Native researchers assert that there is a common ethos—as well as a historical context—among AI/AN tribes (Cross et al. 2000; Goodluck 2002; Goodluck and Willeto 2009; Sarche and Spicer 2008). "Ethos" refers to distinguishing belief systems, attitudes, and values of a group that promote a sense of belonging to the cultural group (Goodluck and Willeto 2009). Aspects of AI/AN ethos and historical experiences influence parenting approaches and developmentally appropriate childrearing practices (Goodluck and Willeto 2009; Sarche and Spicer 2008). A brief overview follows.

Traditional Native Social Structures

Historically, AI/AN cultural groups, or tribes, were self-governing and self-sufficient people who thrived and had sophisticated governance systems and

social structures long before Europeans came to the continent (U.S. Department of Health and Human Services 2001). These systems of social organization defined one's place in that system, relationship to all creation, special roles and responsibilities for upholding community well-being, and valued the dignity of tribal members as important contributors to the tribe as a whole. In addition, the social structures created a natural social safety net that promoted the well-being of young children and helped to protect them from the impact of trauma (Goodluck 2002).

Descriptions of the AI/AN Worldview

In general, "worldview" refers to the beliefs about life and existence held by a group or individual. Cross et al. (2000) described the worldview of AI/AN peoples as "relational" in that it emphasizes the connectedness of all things regardless of time, space, or physical existence. A relational worldview is influenced by an intimate relationship with, understanding of, and spiritual connection to the land, sea, animals, plants, and the universe (Goodluck and Willeto 2009). In addition, "balance and harmony in relationships is the driving principle of this thought system, along with the interplay of spiritual forces…. Health or wellness is achieved by maintaining balance among the many interrelating factors in one's circle of life" (Cross et al. 2000, p. 20).

The AI/AN relational worldview is reflected in the concept of family. Kinship and clan relationships are the glue that binds communities together and are central to their way of being. Consequently, AI/AN cultural groups develop a strong sense of belonging, not only to one's family, but to their larger group as well. The relational worldview emphasizes group identity, cooperation, cohesiveness, and reciprocal assistance over individuality, independence, aggressive competitiveness, and conflict (Glover 2001). The relational worldview, along with traditional values and social and kinship structures, is central to AI/AN tribes' physical, social, and spiritual well-being. Although each tribe has its own unique surface structure expression of this relational worldview, and of bringing balance and order back to an individual, family, or community—the underlying deep structure meaning is consistent across tribes.

Concept of Family

The extended family structure characterizes the AI/AN concept of family and typically includes those related through blood or marriage (i.e., parents, grandparents, aunts, uncles, cousins), as well as "those related by clan, informal adoption, spiritual ties, and other tribal community recognition processes" (Goodluck and Willeto 2009, p. 2). An extended family structure reflects an emphasis on "interdependence, reciprocity, and obligation to care for one another" (Sarche and Spicer

2008, p. 6). Among the shared values of AI/AN tribes is the importance of children and elders. Elders are highly respected and hold an esteemed place as the traditional bearers of wisdom and knowledge who pass on family and tribal traditions, history, stories, and practices that convey beliefs and values to live by (Glover 2001; Sarche and Spicer 2008).

Goodluck (2002) conducted an exploratory research project that investigated American Indian well-being or family strengths. Moore et al. (2002) defined family strengths as "the set of relationships and processes that support and protect families and family members, especially during times of adversity and change. Family strengths help to maintain family cohesion while also supporting the development and well-being of individual family members" (p. 1). Goodluck (2002) identified 42 American Indian family strengths organized into 10 major themes, specifically:

1. Importance of spirituality (e.g., healing practices, rituals);
2. Power of the group (e.g., interdependency, reciprocity);
3. Relevance of identity (e.g., cultural and tribal identity);
4. Political relationships (e.g., resistance, sovereignty);
5. The next generation (e.g., view of children, childcare customs);
6. Our values (e.g., optimism, respect);
7. Our voice (e.g., language, via stories);
8. Education (e.g., tribal colleges);
9. Environment (e.g., relationship to land);
10. Methods (e.g., traditions, overcoming trauma).

Native Children and Parenting

Children in Native communities are regarded as gifts from the creator and are respected as individual manifestations of the spiritual world (Sarche and Spicer 2008). Because of their spiritual status, they are not viewed as their parents' property but are respected as autonomous beings (Goodluck 2002; Sarche and Spicer 2008). Children are made to feel that their participation with and contributions to the family are important. "Indigenous beliefs assumed that each child possessed qualities to develop into a worthwhile individual with caregivers encouraging correct behavior by acknowledging traits that would be helpful as the child grew older" (Bigfoot and Funderburk 2010, para. 4).

Children are often cared for by their extended network of relations who play an important role in childrearing, including applying discipline. Bigfoot and Funderburk (2010) stated, "It is helpful to view discipline as the teaching of self-control as opposed to only punishment. For many Tribes, self-discipline is highly prized, as demonstrated by traditions of fasting, vision quests, endurance during ceremonies, or self-denial in ceremonies" (para. 5). Within the traditional AI/AN worldview are deeply ingrained social cues about how to exist in order to maintain community order, consequences and dangers of stepping out of harmony,

and behavioral expectations. Traditional AI/AN cultures are based on oral traditions and children are taught by example. Thus, listening, observing, and remembering are desired aptitudes that are valued, taught, and praised over verboseness (Goodluck and Willeto 2009; Sarche and Spicer 2008). Social cues for appropriate and inappropriate behavior, then, are often communicated to children through storytelling and reinforced through traditional ceremonies. Children are allowed to learn through practice and trial and error as a way of perfecting their skills. In addition, teaching practices use place-based experiential learning and observation that extends beyond human relationships to the land, animals, plants, and one′s place in the universe (Barlow and Walkup 1998).

Historical Trauma and AI/AN Populations

The public health field has focused on the theory of historical trauma as a proposed explanation of why populations that directly experience long-term, mass trauma (e.g., slavery, genocide) tend to exhibit a high prevalence of physical, social, emotional, and behavioral problems, and subsequent generations are often affected by the impairment of parenting capacities from those with direct trauma experience (Brown-Rice 2013; Faimon 2004; Sotero 2006; Wesley-Esquimaux and Smolewski 2004). Sotero (2006, pp. 94–95) listed four assumptions that undergird historical trauma theory:

1. Mass trauma is deliberately and systematically inflicted upon a target population by a subjugating, dominant population.
2. Trauma is not limited to a single catastrophic event, but continues over an extended period of time.
3. Traumatic events reverberate throughout the population, creating a universal experience of trauma.
4. The magnitude of the trauma experience derails the population from its natural, projected historical course resulting in a legacy of physical, psychological, social, and economic disparities that persists across generations.

Maria Yellow Horse Brave Heart and Lemyra DeBruyn defined historical trauma among AI/AN cultural groups as “the cumulative and collective psychological and emotional injury sustained over a lifetime and across generations resulting from massive group trauma experiences” (cited in Sotero 2006, p. 96). The migration of European settlers to the Americas resulted in centuries of conditions and experiences that created historical trauma for Native populations (Brave Heart et al. 2011; Cole 2006; Goodluck and Willeto 2009). Two examples of deliberate and systematic trauma experiences that directly impacted AI/AN children, parents, and family life are Federal Indian Policy and American Indian Boarding schools.

Federal Indian Policy. While Native populations were already decimated at the founding of the USA by new diseases brought by Europeans, new federal Indian

policies, beginning in the late nineteenth century and continuing into the 1960s, further devastated indigenous social structures and the well-being of tribal nations (U.S. Department of Health and Human Services 2001). Federal Indian policy dictated interventions on what lawmakers perceived as the "Indian problem" that included: (a) state-sponsored bounties for the scalps of Native peoples; (b) state-sponsored policies of genocide, land dispossession, removal from traditional lands, forced assimilation, and isolation from tribal culture; and (c) explicitly targeting the breakup of Native families and the sophisticated community and social systems that were optimal environments for children and family well-being (Goodluck and Willeto 2009; Simmons 2014; The University of Oklahoma Health Sciences Center 2000). For example, as part of the policy of assimilation, the Indian Adoption Project was implemented which placed American Indian children with White families. The policy influenced the entire field of social work, with state-based child welfare organizations adopting the notion that Indian children were best cared for by being removed from their families and placed outside of their families and communities (Goodluck and Eckstein 1978).

The Boarding School Era. Federal Indian Policy gave rise to American Indian Boarding schools. These schools, guided by the slogan "Kill the Indian, Save the Man," focused on ethnic and cultural cleansing (Simmons 2014; Ziibiwing Center of Anishinabe Culture & Lifeways 2011). Generations of children, as young as age four, were forcibly removed from their families and communities and placed in prison-like institutional settings. Children were not allowed to speak their own languages; practice their culture; maintain their traditional names, clothing, or identity; or visit with their families.

These schools introduced punitive childrearing practices, which was foreign to traditional childrearing in Native communities, and were rampant with physical and sexual abuse. To prevent children from running away, Indian boarding schools were geographically distant from their home communities; this created a complete disruption of their early attachments and social connections (Brave Heart et al. 2011). These destructive practices also "distanced families from the protective factors inherent in tribal communities and culture…. The use of these boarding schools affected several generations of tribal families, essentially denying them the opportunity to parent" (Simmons 2014, pp. 1–2).

Sarche and Spicer (2008) asserted, "American Indian and Alaska Native communities today live with a legacy of cultural trauma as a result of centuries of dispossession at the hands of the U.S. government and its policies and practices intentionally designed to break apart culture, communities, family, and identity" (p. 130). While it is important to understand the nature and effects of historical and intergenerational trauma when working with AI/AN children, families, and communities, cultural scientists caution against using this information to pathologize and singularly define AI/AN cultural groups as victims (Moule 2012). For example, based on the information gathered from government archives, student and teacher autobiographies, and school newspapers, Adams (1995) concluded that one of the reasons Indian boarding schools failed to achieve their objective of complete

Table 1 Native conceptualizations of the Strengthening Families (SF) protective factors

Protective factor	SF definition	Native definition
Parental resilience	Functioning well when faced with adversity	Courage
Social connections	Healthy, sustained relationships	Community
Knowledge of parenting and child development	Understanding child development and parenting best practices	Health
Concrete support in times of need	Identifying, seeking, accessing, advocating for, and receiving needed supports and services	Freedom
Social and emotional competence of children	Providing an environment and experiences that enable children to form secure relationships and regulate behavior and emotions	Compassion

assimilation was that many American Indian students resisted and were not passive recipients of an ethnic cleansing curriculum.

It is also important to understand that historic and intergenerational trauma is not predictive. Numerous AI/AN families and communities are working to counter the impact of generations of trauma, loss, and grief. They have persevered against overwhelming odds and have found ways to buffer children against the impact of historical and contemporary trauma. For example, the Strengthening Families Approach and Protective Factors Framework™, developed by the Center for the Study of Social Policy, is a two-generation approach that recognizes the vital role of the parent or primary caretakers in promoting children's healthy development and well-being. The Strengthening Families protective factors function to "(a) prevent or mitigate the effect of exposure to risk factors and stressful life events and (b) build family strengths and a family environment that promotes optimal child development" (Harper Browne 2014, p. 21).

The Strengthening Families Approach has been adopted by several AI/AN cultural groups and adapted to reflect a Native cultural relational worldview that focuses on traditional ways of childrearing and social organization. Native parents in Washington State have translated the protective factors into their own cultural context and tribal values and have trained other parents in their communities and in other tribal communities. Table 1 provides the Strengthening Families definition of each protective factor and a corresponding tribal definition.

Honoring AI/AN Culture in Educational Settings

Understanding and appreciating the influence of American Indian and Alaska Native culture requires knowledge of the impact of historical and contemporary trauma experiences, as well as AI/AN "strengths, abilities, opportunities, and behaviors to handle problems in their own families and communities in the Native American tradition" (Goodluck and Willeto 2009, p. 1).

Knowledge of these aspects of AI/AN culture and the impact on parenting beliefs, values, approaches, and expectations can enable early care and education providers to be better prepared to interact more effectively with American Indian and Alaska Native children, parents, and families. But, as previously indicated, the process of acquiring cultural competence must be accompanied by conscientiously engaging in cultural humility. Providers must be humble enough to acknowledge what they don't know or understand about AI/AN culture and historical experiences, and their desire to engage in a collaborative and reciprocal learning process in which AI/AN parents and non-AI/AN providers learn from each other.

Early care and education providers can work with AI/AN children and their families in ways that affirm their cultural values, culturally appropriate behaviors, skills, and ways of being. For example, Head Start leadership developed AI/AN programs in recognition of "the significance of Native American customs and heritage to tribal members (which) necessitated different (program) practices and curricula" (Zigler and Styfco 2010, p. 130). In 2012, the Alaska Department of Education and Early Development published the *Guide to Implementing the Alaska Cultural Standards for Educators* "to help educators incorporate the cultural standards into their instruction and curriculum, making their practice more culturally responsive to their students and the communities in which they work" (p. iv). The culturally responsive standards and instructional practices outlined are generalizable to a broad range of cultural groups. Specifically, the five standards are as follows:

1. Culturally responsive educators incorporate local ways of knowing and teaching in their work.
2. Culturally responsive educators use the local environment and community resources on a regular basis to link what they are teaching to the everyday lives of the students.
3. Culturally responsive educators participate in community events and activities in appropriate and supportive ways.
4. Culturally responsive educators work closely with parents to achieve a high level of complementary educational expectations between home and school.
5. Culturally responsive educators recognize the full educational potential of each student and provide the challenges necessary for them to achieve that potential.

Conclusion

Parenting is a cultural act. Children's developmental outcomes are influenced by parenting practices, and parenting practices are influenced by cultural factors. Early care and education providers who work with culturally diverse families need to be aware of and sensitive to cultural differences in parents' behaviors, values, and expectations. Knowing about and being responsive to cultural differences is important for policy makers as well, in order to avoid narrow decisions that reflect

the presumption of one "right"—that is, ethnocentric—way of parenting. By honoring diverse parenting strengths, values, expectations, and approaches, providers and policy makers demonstrate an understanding and appreciation of multiple and very different pathways to parenting and promoting optimal child development. Thus, cultural differences should be considered to be an asset, not a deficit, for the healthy development and well-being of children, families, communities, and the society at large.

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Strong Start for Families: An Innovative Use of High Fidelity Wraparound with Mothers in Early Recovery from Substance Use Disorders

M. Kay Teel

A confirmed pregnancy, even when unplanned and unintended, is a powerful motivator for a woman to curtail her use of alcohol and other drugs in the interest of her expected child. A woman who uses alcohol or other drugs during pregnancy increases the risk of harm to her child's health and development from prenatal exposure, and her parental role functioning may be impaired if she cannot provide adequate care and protection for her young child. Most women with substance use problems also have untreated mental health conditions and many are low-income making it difficult to meet the basic needs of the family. This chapter provides a comprehensive overview of the issues that must be considered for effective intervention to enhance the understanding of this vulnerable population. The chapter describes a novel, team-based Wraparound systems of care approach used in a recent initiative called the Strong Start Study to facilitate access to resources and provide these families with additional support during early recovery. Details of this innovative intervention are provided, and implications for social policy are discussed.

Behavioral Health During Pregnancy

A recent national survey in the USA found maternal substance use during pregnancy is highest at 9 % among younger women ages 18–25 and drops to 3.4 % for women ages 26 and older (Substance Abuse and Mental Health Services Administration [SAMHSA] 2013a). The earliest gender-based research on addiction found that women are motivated to reduce or stop their use of drugs during

M.K. Teel (✉)
University of Colorado, 1320 Stuart Street, Denver, CO 80204, USA
e-mail: mkteel2@gmail.com

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pregnancy in the interest of their expected child (Rosenbaum 1981). Pregnancy is a major life event that provides the opportunity for motherhood desired by most women as a way to participate in conventional life; having children and being a mother can be especially important for low-income women who may have fewer avenues for personal satisfaction and achievement in their lives (Murphy and Rosenbaum 1999). Women with substance use problems that are mothers have been found to have similar hopes for their futures as other women without substance use problems—a job, health and mental health, and a healthy family (Sterk 1999). Fear, stigma, and shame are often barriers to these same women seeking help, especially when they are pregnant (Jessup et al. 2003; Murphy and Rosenbaum 1999).

Co-occurring Disorders The strong correlation between substance use and mental health problems has long been recognized (Bolton et al. 2009; Robinson et al. 2009; Leeies et al. 2010) and is referred to variously as dual diagnosis, comorbidity, and co-occurring disorders. When compared to men with co-occurring disorders, women have higher rates of major depression, PTSD, and other anxiety disorders (NIDA 2007). For women who develop substance use problems that have higher rates of dysthymia and other mood disorders, there is evidence suggesting alcohol and other drugs are used to self-medicate to relieve emotional distress and reduce anxiety (Leeies et al. 2010; Bolton et al. 2009). The likelihood of depression and substance use increases significantly with risk factors associated with unintended pregnancy, low-income, high school or lower educational level, intimate partner violence (IPV), and lack of support (Goyal et al. 2010; Lancaster et al. 2010).

Birth and Parenting Outcomes A woman's physical and behavioral health status during pregnancy are mediators of birth outcomes for her child and have implications for parenting. Low-income women with greater life stress, untreated mental health conditions, and substance use during pregnancy have an increased risk of preterm birth (PTB) and low-birth-weight (LBW) infants (Ding et al. 2014; Gavin et al. 2012). Women with depression or PTSD from IPV during pregnancy may be less responsive to their child's emotional cues (Schechter et al. 2015), perceive their child as having a difficult temperament at one year of age (McMahon et al. 2011), or have a harsh parenting style when their child is a toddler (Kim et al. 2010). These findings underscore the importance of effective behavioral health interventions for low-income women during pregnancy to improve both birth outcomes and parental role functioning.

Low-income Mothers Recent research has operationalized the impact of poverty on both children and their parents as cumulative, chronic stress (Evans and Kim 2013; Broussard et al. 2012). The sources of the stress associated with poverty reflect the often impoverished physical and social environments that low-income families live in day-to-day. These communities are characterized by poor housing conditions, limited access to health and mental health care, and often chaotic social environments (Broussard et al. 2012; Onigu-Otite and Belcher 2012). The stress experienced can be even greater when there is ongoing family conflict or violence (Evans and Kim 2013). Low-income mothers have concerns about these

environmental conditions on their young children, yet lack resources to relocate or change their situation (Broussard et al. 2012). The psychosocial stress experienced by low-income mothers of color can be exacerbated by the additional burden of racism and discrimination (Broussard et al. 2012). While single, low-income mothers do find positive ways of coping through faith, humor, and family support, they also have higher rates of substance use disorders (Broussard et al. 2012).

Maternal and child health are closely aligned, especially with low-income mothers and young children given the increased social and environmental risks to both. Compared to the general population, low-income women have significantly higher rates of mental health and substance use disorders yet only 25 % receive treatment (Rosen et al. 2006). Low-income mothers have higher rates of depression and anxiety but often do not seek help with these mental health problems due to their perceptions of both the nature of their concerns and the risk of negative consequences should their problems be disclosed, specifically, their children being removed from their care (Anderson et al. 2006).

Contending with constant physical and mental stress without adequate resources can affect parental role functioning of low-income mothers in ways that could raise concerns regarding the care of their children. As an ecological factor, family income can have a moderating effect on child health and well-being. Research has shown that where income is lower, there are higher rates of child maltreatment (Eckenrode et al. 2014) and that poverty is a more significant factor in re-occurring maltreatment than a parent's mental health status or substance use disorder (Escaravage 2014).

Social Support, Health and Behavioral Health The relation between social support and well-being is central to addressing both the health and behavioral health needs of this population. The existence of positive relationships and the resources, tangible and intangible, they can provide are important aspects of "buffering" a person from stress (Cohen and Wills 1985). As such, the availability and quality of social support are recognized as a protective factor for health, especially with chronic conditions (Cohen 2004; Reblin and Uchino 2008). Social support can be "instrumental" by providing concrete resources, "informational" by providing advice or guidance, or "emotional" by providing empathy and caring (Cohen 2004).

Social Support and Recovery The importance of social relations to health outcomes has been the focus of recent research comparing treatment outcomes and the development of positive social networks in helping women sustain recovery (Ellis et al. 2004; Min et al. 2013). Improved family relationships that result in less conflict are significant in preventing relapse, while poor family relationships increase risk of relapse (Ellis et al. 2004). Women also benefit from the support and acceptance of a family member involved in the treatment process, as well as the emotional support and motivation from the relationships with their children (Tracy and Biegel 2006; Tracy and Martin 2007).

Social Support During the Postpartum Period Social support was the number one need identified in a national sample of new mothers during the first-year

postpartum indicating the universal importance of connections with others when caring for a young child (Kanotra et al. 2007). For low-income women, however, chronic stressors related to poverty impact the potential social support from family and friends who may be experiencing hardship in their own lives. These social networks cannot provide the same buffering effect with stress and are less likely to provide support for recovery (Mulia et al. 2008). When this "private safety net" of support is insufficient, alternative sources of support are essential for a woman to sustain her recovery (Mulia et al. 2008).

Positive social supports can be especially important for women with co-occurring mental health conditions in helping them sustain their recovery from substance use, reducing mental health symptoms, and increasing their sense of well-being (Laudet et al. 2000). Women in recovery with co-occurring disorders including PTSD have more histories of childhood maltreatment from physical or sexual abuse, and experiences of intimate partner violence in their adulthood (Brown et al. 2015). However, when women have significant trauma symptoms, fewer social supports are available to them (Brown et al. 2015), and the quality of the social network they do have tends to be more negative and critical (Min et al. 2013).

Women's Substance Use Treatment

In 2012, pregnant women represented 4.8 % of all admissions to substance use treatment programs, a percentage that has remained relatively stable over the past decade (SAMHSA 2013b). Federal policy designated set aside public funding for substance use treatment for pregnant and postpartum women in the Anti-Drug Abuse Act of 1988 (P.L. 100–690) marking official recognition of the healthcare needs of this patient population. The social role of women in bearing and caring for children as a critical aspect of their special health and behavioral health needs in treatment has been consistently acknowledged (Greenfield et al. 2003). Low-income pregnant and postpartum women must rely on publicly funded treatment programs, and those who access and continue in treatment have better birth outcomes with fewer preterm births and low-birth-weight infants (Niccols et al. 2012a).

Substance use treatment programs for pregnant and postpartum women (PPW) typically provide comprehensive services to achieve the overall goal of healthy family functioning (Magura and Laudet 1996; Uziel-Miller and Lyons 2000; Werner et al. 2007). Longstanding barriers to treatment for PPW persist, however, including the fear and shame of disclosing substance use to a healthcare provider especially in the context of prenatal services (Jessup et al. 2003). Low-income pregnant women admitted to publicly funded treatment programs must meet Medicaid-eligibility requirements. Their economic status and resulting lack of resources to meet basic family needs often contribute to the complexity of their lives during the period of early recovery and has informed the comprehensive treatment programming recognized as necessary to address those needs (Ashley et al. 2003; Knight et al. 2001; Sun 2006).

Treating Co-occurring Disorders The co-occurring mental health needs of PPW in substance use treatment are often not specifically addressed due to the lack of integration of behavioral health services (Covington 2008; Grella 1997; Saladin et al. 1995). These system-level gaps can undermine both the full participation of this population of women in substance use treatment and ultimately their recovery efforts. For substance use treatment programs to be effective in engaging and retaining women, trauma exposure must be understood (Covington 2008) and services provided through a trauma-informed approach. When programs are trauma-informed, symptoms decrease, and substance use treatment outcomes are improved (Lopez-Castro et al. 2015). Without an integrated behavioral health system to date, the capacity of specialized treatment programs to provide the services necessary to effectively address mental health needs remains a challenge to the field (Gil-Rivas and Grella 2005).

Treatment outcomes Women, who are married, have fewer children, more social supports, and less trauma exposure, have better outcomes from substance use treatment (Greenfield et al. 2007). Demographics of being older, having more years of education, and higher income are also positively correlated with better treatment outcomes (Knight et al. 2001; Greenfield et al. 2007). Positive treatment outcomes for PPW include a reduction in substance use, fewer mental health symptoms, and better maternal health status (Ashley et al. 2003). Gender-specific programs have higher retention rates attributed to allowing children in residence with the mother or providing child care, individualizing services with supportive, nonjudgmental staff, and coordinating comprehensive service needs (Ashley et al. 2003; Sun 2006). Young children whose mothers participate in treatment have better birth outcomes and better emotional and behavioral functioning compared to children whose mothers are not in treatment; no difference was found, however, in child welfare involvement when mothers were in treatment (Milligan et al. 2011; Niccols et al. 2012b).

Child Maltreatment

Enactment of Public Law 108-36 known as the Keeping Children and Families Safe Act added amendments to the Child Abuse Prevention and Treatment Act (CAPTA) requiring states that receive federal funding to have in place policies and procedures related to "…infants born and…affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure…" (Sect. 106(b)(2)(A)(ii)). Each state has discretion in determining how this legislative mandate is met. A common child welfare response is removal of newborns from the parent and placement with either a relative or in foster care. Other federal child welfare laws require a timely resolution to the conditions that resulted in out of home placement of the child, typically 12 months. If the parent has not followed the treatment plan developed by child welfare and included in court orders, then parental rights can be terminated, and the permanency plan for the young child is often non-relative adoption.

Prenatal Substance Exposure and Newborns In response to the CAPTA amendment, states and local jurisdictions have implemented screening of newborns suspected of being prenatally exposed to illegal drugs. A positive toxicology screen results in child welfare involvement and a determination regarding the harm or risk of harm to the infant and whether the child is safe to remain in the care of the mother. When controlled for maternal substance use and other demographic variables, the conditions predictive of removal of newborns include lack of prenatal care, mothers with evident psychological distress, and poor coping behaviors (Minnes et al. 2008).

Women with both substance use and mental health conditions with newborns are more likely to have child welfare authorities remove their child (Grant et al. 2011; Minnes et al. 2008). Mothers who lose custody of their newborns are more likely to have histories of maltreatment in their lives involving emotional neglect and physical abuse (Minnes et al. 2008). National data shows that when an infant is removed due to maternal substance use and placed in out of home care, fewer than half are reunified with their birth parents (Wulczyn et al. 2011).

Child Welfare Intervention When a newborn is removed by child welfare due to maternal substance use, it is common for the family to have multiple problems and complex needs that must be addressed for reunification of the parent and child. The typical needs of mothers with substance use problems are related to mental health, substance use treatment, housing, and family therapy (Choi and Ryan 2007). These mothers as a group have limited resources, low levels of education, lack job skills, and often have previous involvement with child welfare related to their substance use and birth of another child (Choi and Ryan 2007). A review of the service needs identified by child welfare with these families found 76 % had over four areas of needed services and that 29 % had over seven areas of needed services (Choi and Ryan 2007). The review also found that despite this high level of service needs, there was a low level of service utilization indicating the need for the child welfare system to identify and address barriers experienced by families in receiving services (Choi and Ryan 2007). When families have a child in out of home placement, the most critical service needs are mental health and substance use treatment that specifically address the mother's trauma experiences (Jarpe-Ratner et al. 2015).

Mother's mental health status In a national sample of caregivers of young children who had been investigated for a maltreatment referral, child welfare caseworkers identified problems with depression in 30 % of caregivers. Caseworkers were more likely to assess for mental health needs if the referral source was a health or mental health provider, the child was under one year of age, and a standardized assessment tool was routinely used; higher child welfare caseloads were associated with lower identification of caregiver mental health needs (Chuang et al. 2014). The study concludes that parental depression, especially with mothers of young children involved with child welfare is under-identified, and if not identified cannot be addressed through the service plan and needed mental health treatment. The prevalence of depression among caregivers of young children has been confirmed in another study with 25 % of caregivers reporting symptoms of major depression

within the 12 months prior to child welfare investigation; on follow-up, depression among caregivers increased to 45 % with contributing factors identified as intimate partner violence and physical health problems (Casanueva et al. 2011).

Reunification outcomes When mothers with substance use problems and their children become involved with child welfare, the services they receive are significant factors in reunification. Mothers more likely to be reunified with their child following out of home placement received more substance use treatment and mental health services, had sustained their recovery over a longer period, and had support for their recovery (Grant et al. 2011). By comparison, mothers who did not regain custody of their children were found to have more serious mental health problems, received fewer services, did not have a supportive partner, and did not complete treatment for substance use; they also had more "replacement" babies who also experienced prenatal exposure (Grant et al. 2011, 2014). Mothers who completed substance use treatment and regained custody were found to reporting fewer problems in their home and community environments compared with mothers who did not complete treatment; these mothers reported more moves and less stability (Kyzer et al. 2014).

The Strong Start Study: Collaboration, Implementation, Challenges, and Outcomes

The purpose of the Strong Start Study was to examine the effectiveness of a collaborative intervention in preventing maltreatment of infants and toddlers whose mothers were in early recovery from substance use disorders. Women who were pregnant and enrolled in substance use treatment participated in the study with half receiving a High Fidelity Wraparound intervention in addition to standard treatment. The study monitored the health and development of the infants due to experiencing prenatal exposure to alcohol and other drugs and facilitated the evaluation process with IDEA Part C for early intervention services when indicated.

Collaborative Partnership: Women's Treatment, Part C and Wraparound The collaboration brought together at the state-level women's substance use treatment and Part C early intervention. A state university program with expertise in children with special needs and with Wraparound as a systems of care approach staffed the study and conducted the evaluation.

Women's Substance Use Treatment Specialized treatment for pregnant and postpartum women (PPW) with substance use disorders is funded by federal block grants to each state through the Substance Abuse and Mental Health Services Administration (SAMHSA). As a group, PPW are considered high priority in accessing substance use treatment and programs must address their multiple and complex needs comprehensively. The Strong Start Study was conducted in a large metropolitan area that represented a designated service area for publicly funded substance use treatment. Within that area, there were two outpatient programs for

PPW and one sixty-day residential program. Once admitted into treatment with a confirmed pregnancy, a woman could receive services until one-year postpartum as long as she remained eligible for Medicaid. While the state office of women's treatment was the collaborative partner with the study, each of the treatment programs agreed to subcontracts to support their involvement of staff in identifying eligible women for the study, referring them for enrollment, and participating on Wraparound teams.

Part C Early Intervention Early intervention services for eligible young children through age 2 who have developmental delays or disabilities are governed through Part C of the Individuals with Disabilities Education Act (IDEA). As a collaborative partner in the study, the state office for Part C services provided guidance on screening and referral of infants needing evaluation for developmental concerns. As an example, the study was encouraged to build in routine developmental screening with a parent report tool as a basis for referring into the Part C system for further evaluation. In the state where the study was conducted, Part C Child Find responsibilities are held with the local school district where the child and family lives, and service coordination provided through local nonprofit organizations at the county level. At the time of the study, fetal alcohol syndrome (FAS) diagnosis was the only condition related to prenatal substance exposure designated as meeting categorical eligibility for Part C services.

High Fidelity Wraparound Since the 1980s, Wraparound has been considered an intensive care coordination approach that is used primarily with children and youth who have serious emotional and behavioral challenges. Use of this team-based Wraparound approach allows children and youth to remain with their families in their home communities with an individualized, integrated plan for services from multiple agencies to meet their needs and those of their families (Bruns and Walker 2011). Wraparound is grounded in the principles of service delivery through a collaborative system of care that emphasizes family "voice and choice" in all aspects of treatment, community-based rather than institutional care, and engagement of natural support of family and friends as resources (Bruns et al. 2010; McGinty et al. 2013). Initiated largely through federal SAMHSA grants, Wraparound has been implemented in over forty states as the primary practice model for developing a systems of care approach for behavioral health that is both strengths based and family driven (Bruns et al. 2011; Kilmer and Cook 2012; Winters and Metz 2009). The Wraparound process is being used successfully with other populations of different ages, and with other evidenced-based treatment models with adaptations that adhere to the value base and maintain fidelity to the standards for practice (Bruns and Walker 2011; Bruns et al. 2014; Mendenhall et al. 2013; Stroul et al. 2010).

Key elements of fidelity to the Wraparound process include implementation of the four phases and activities of the model by trained staff based on an understanding and application of the theory of change at the individual and family levels to facilitate collaboration in service delivery across systems (Walker et al. 2004; Vroon Vandenberg 2005). The VroonVanDenBerg theory of change for

Wraparound is informed by Maslow's hierarchy of needs (1970), Bandura's theory of self-efficacy (1977), and Bronfenbrenner's theory of human ecology (1979), conceptualized by (1) the family determining their most important, priority needs, (2) the development of self-efficacy through small, doable steps, and (3) inclusion of the natural support system (Vroon Vandenberg 2005). The fourth concept of an integrated planning process is the written documentation of the Wraparound team's collaboration in identifying with the family their service needs, the providers of those services, and other supports and resources identified in helping the family meet its needs. The Wraparound plan incorporates the requirements and goals of all other treatment plans for the parent and child to become the blueprint for the family's Wraparound team.

A growing body of research literature on the effectiveness of Wraparound continues to underscore the need for the approach to be implemented with fidelity to the model for better outcomes to be realized (Bruns et al. 2005, 2015; Suter and Bruns 2009). The Wraparound Fidelity Index—version 2 has been the standard measure of fidelity and is based on caregiver, team member, and facilitator ratings of adherence to the principles and activities during the implementation of Wraparound.

Implementing Strong Start Wraparound Wraparound with women in recovery who are parenting infants is not intended to provide specialized substance use or mental health treatment. Rather, the Wraparound process is intended to provide the facilitated collaboration between and among the multiple systems providing services for the woman and her child. The Wraparound intervention used in the Strong Start Study was grounded in the principles, theory, and practice standards developed through the National Wraparound Initiative (http://www.nwi.pdx.edu/). *Wraparound* is not a service, per se. It is a facilitated process of team-based planning and collaboration designed to address complex behavioral health needs. Low-income mothers in early recovery from substance use who are parenting infants and other young children have complex needs and are often involved with multiple systems such as child welfare, substance use treatment, mental health, and probation. The hypothesis tested was that Wraparound in addition to substance use treatment would provide additional supports and access to resources to help mothers in recovery function adequately in their parenting role, thereby preventing maltreatment.

Pregnant women 18–44 years old who entered specialized substance use treatment programs, Special Connections, were invited to participate in the Strong Start Study and were informed about the study during their admission to the treatment program. Baseline data on 84 women was collected upon enrollment into study; baseline data on the infant was collected at 3 months of age. Post-data collection was done at one-year postpartum for both the mother and the child. After completing baseline data collection, participants were randomized to either the Wraparound intervention group or standard treatment comparison group. Software was utilized to determine the group assignments were equivalent in three baseline characteristics known to be related to the outcomes: (1) an open child welfare case,

(2) parental rights terminated on another child, and (3) court ordered to be in substance use treatment.

Wraparound Staffing Roles Each participant randomized into the Wraparound group was assigned a Wraparound facilitator and a family support partner (FSP) who contacted them to begin the engagement phase of the process. Wraparound staff complete an initial training on the principles of the approach and the expectations of the respective roles in the process. Staff participate in ongoing coaching and supervision of their activities with participants and must demonstrate competency in explicit skill sets for certification.

Wraparound Team Facilitator The facilitator has the lead responsibility for initial engagement with the participant and the preparation of the Discovery document to be shared with the team. Based on the professionals and natural supports identified by the woman, the facilitator contacts and interviews potential team members and prepares them for their role on the team. The facilitator is responsible for facilitating team meetings and preparing the written Wraparound plan document that is updated following each meeting and made available to team members.

Family Support Partner (FSP) During the engagement phase, the FSP helps prepare the woman for the initial team meeting and is available during the team meeting in a supportive role as well. The preferred characteristics of the FSP in the Wraparound process is that they have life experience similar by being a mother who has had a substance use disorder and has sustained her recovery over time. The role of the FSP is to be a peer mentor for the woman and assist her in taking identified action steps toward her goals between team meetings. The motto of the Wraparound FSP is "do for, do with, cheer on," reflecting the progression of the relationship and leadership shifting to the woman in early recovery with the FSP continuing to provide encouragement and support. In this study, the FSP had an additional role with the women when their babies were born of assisting the mother in completing the Ages and Stages Questionnaire to screen for developmental milestones. When there were concerns about delays, the FSP assists the parent with a referral to the local Part C Child Find for an evaluation to determine whether the infant is eligible for early intervention services.

Phases and Activities of Wraparound Participation in Wraparound begins through the initial *engagement phase* with the family in a comprehensive discovery process to identify their priority needs, their preferred ways of relating, and their hopes for the future. The goal of discovery is to understand the life of the family from the family's own perspective. The conversations during the discovery are strengths based and intended to identify with the family what is working for them, what inherent positive qualities and characteristics the members possess, and what hopes they hold for their future described as the family vision statement. Aspects of life common to all families, referred to as "life domains," are explored with them. In the study reported here, ten such universal life domains were considered with each family: health and mental health including recovery, family relations, financial and sources of income, housing, education or vocational training, transportation, legal

matters either civil or criminal, social relations and recreation, spirituality, and civic or community involvement.

During discovery, the family is asked to identify possible team members of both professionals involved with them and natural supports of family members and friends. The facilitator contacts those identified as possible team members for phone or in-person interviews. The purpose of these interviews is for the facilitator to meet the potential team member and overview the Wraparound process and discuss the role of team members. Two questions are asked of potential team members regarding the family: (1) What are the priority needs of the family from the perspective of the prospective team member? and (2) What were the strengths of the family as known to them? Based on the conversations with the family and the identified team members, the facilitator drafts the Strengths, Needs, Culture Discovery (SNCD) document including the family vision statement. The family support partner (FSP) reviews the SNCD with the family who is invited to make any corrections or edits to the document before it is shared with other team members.

During the *engagement phase*, participants are asked about any life circumstance that may require immediate attention to address through crisis planning. This is asked routinely in the Wraparound process to identify any situation that could be further destabilizing to the family. In this study with women who were pregnant and in early recovery, this question was asked specifically in relation to relapse prevention. Treatment programs typically develop a relapse plan and if there is one in place, the woman is asked if she is comfortable with the plan and if she would share the plan with her team so they can provide additional supports should she need them. This was called the Safety Plan for the infant and was in place before birth and updated with the team and treatment provider once the child was born. Disclosure regarding mandated reporting status of all Wraparound staff is a routine advisement given during engagement. For this study, the additional agreement with the participant was that she would be informed by Wraparound staff beforehand if there were concerns regarding the safety of her child and a report needed to be made.

The *planning phase* in Wraparound begins with the initial team meeting. The family vision and the family's priority needs as identified in the SNCD inform the creation of a team mission statement that serves as the guide and reference for the planning process and represents a contract with the family based on Wraparound principles that include respect for family voice and choice, cultural preferences, and the key role of natural supports. Inclusion of family and friends was often challenging due to substance use by those closest to the woman in recovery, yet even one consistent and reliable natural support person on the wraparound team proved important based on the quality of the relationship. Professional support persons typically included the treatment provider, a child welfare caseworker, and a probation officer. Participation by these professionals varied significantly from one team to another and from one jurisdiction or agency to another.

During the first meeting, the team developed the initial Wraparound plan by identifying specific ways to attain the goals in meeting the family's basic needs.

Once the team established priority goals and identified action steps, they systematically reviewed and revised progress or roadblocks, holding participants accountable while supporting their follow-through and attainment of goals. Through the Wraparound team-based planning process, the woman's identified strengths were considered inherent resources to be drawn upon in addressing priority needs and attaining related goals. The team represented a consistent and reliable source of support, helping the woman take care of herself so she is better able to take care of her child. Scheduling of team meetings needed to be flexible in order to allow participation by family members, including fathers, and other supports. Teams met in various locations including the family home, the treatment facility, a church, a jail, and a hospital. Such flexibility facilitated participation when transportation presented a barrier to the family. At times, however, these meeting sites and family-friendly times were barriers for some professional support persons when their agency did not allow for community-based or meetings after business hours.

The *implementation phase* of the Wraparound process began with the action steps identified and assigned to respective team members from the first planning meeting and continued through completion of the plan when priority and subsequently identified needs had been addressed. Wraparound participants were consistent in their agreement that, of all their needs, recovery—framed within the life domain of health and mental health—was the highest priority on which attainment of all other needs depended. Other priority needs following recovery were ranked as follows: legal, family relations, financial, and housing. These priority needs were reframed as goals that were the intended outcomes of each identified action step along the way. As the family's progress in addressing needs was evident to the team, or as the one-year postpartum time approached, the *transition phase* of Wraparound began. The facilitator and family support partner met with the participant to acknowledge successes in goal attainment, to identify ongoing needs, and to determine whether adequate supports and services were in place for both the mother, her children and family beyond the facilitated Wraparound process. A written summary was prepared for review with the team as scheduling of final team meetings, any additional planning, and a celebration with the family was discussed. Included in the transition plan is the women's preferences for continuing the Wraparound team informally as a source of ongoing support that she would facilitate, and any follow-up contact to check in with the Wraparound staff.

Challenges Encountered A primary challenge encountered by the study was the lack of a formalized relationship with child welfare agencies in the four counties where the study was conducted, although outreach was done as the study began. As research being conducted for primary prevention of maltreatment, the study design did not consider the number of families enrolled that had open child welfare cases with another child, nor was this an exclusionary criteria. The challenge was the engagement of the assigned caseworker with the Wraparound team and their collaboration as a team member as they were under no agency agreement to participate.

Logistical challenges were encountered with multiple jurisdictions within the metro area where the study was conducted and four different local service systems. When a participant moved and crossed a county line, all local services had to be initiated based on the new residence. Families were also involved with civil or criminal cases in multiple jurisdictions simultaneously making the inclusion of attorneys and related professionals on the Wraparound team difficult.

A fundamental challenge in providing Wraparound to this population in this state and location was the limited public funding for longer term residential treatment programs available for pregnant and postpartum women. The one residential program involved with the study was a 16-bed facility with a sixty-day program that limited the time needed for stabilization and maximum treatment benefit. Each mother with her infant required two beds resulting in very limited capacity of eight mother–child dyads.

Outcomes of the Strong Start Study

Seventy-four percent of participants randomized into the Wraparound intervention engaged in the process, established a Wraparound team, and held initial team meetings for integrated planning purposes. Families in the study participated in Wraparound an average of 10.8 months, with a range of 4–18 months, and had an average of 6.8 team meetings, with a range of 2–21 team meetings. Post-intervention data were collected at 12-month postpartum on 64 women for a retention rate in the study of 76.2 %. Following completion of the formal Wraparound process, participants completed the Wraparound Fidelity Index (WFI-4). Responses to the WFI fidelity items resulted in a scoring of 1.64 out of a possible 2, indicating a fidelity rating for the implementation of the intervention in the study of 0.82 or roughly 82 % of full fidelity. This level of fidelity to the Wraparound model gives confidence in the results of the study while also suggesting potential for improvement in the process.

Participants Participants' ranged in age from 18 to 42 with the average being 27 years. Almost half of the participants (48 %) were either married to or living with a partner. Racial identification was White 41.8 %, Black 12 %, Native American 12 %; 31.6 % identified their ethnicity as Hispanic, and 2.6 % indicated multiracial/ethnic identities. Half of the participants (52.4 %) had completed high school or the General Educational Development (GED) test, while 32.1 % had completed middle school. All participants were low income and met Medicaid-eligibility for treatment. Women were admitted to treatment and enrolled in the study at different stages of pregnancy with 19 % enrolling during the first trimester, 48 % enrolling during the second trimester, and 24 % enrolling during the third trimester. The remaining 12 % enrolled during late-term pregnancy and gave birth before beginning the Wraparound intervention. The primary drug being used at admission to treatment was cocaine (17.9 %), cannabis (16.7 %),

amphetamines and heroin at 11.9 % each, other opiates (10.7 %), alcohol (8.3 %), and hallucinogens, methadone, and sedatives at 1.2 % each. Major problems with both alcohol and drugs were indicated by 8.3 % of participants, and polydrug use by 10.7 %. At the time of enrollment into the study, half of the total sample (51.2 %) had previous involvement with Child Welfare and 16.6 % had an active child welfare case. Additionally, 16.7 % of participants with previous child welfare involvement due to substance use had their parental rights terminated on one or more children.

Priority needs A review of initial Wraparound plans found the priority needs identified by pregnant women in early recovery were ranked by domains as follows: (1) health/mental health/recovery, (2) legal, (3) family relationships, (4) financial/income, (5) housing, (6) education/training, (7) transportation, (8) social/recreational, (9) spirituality, and (10) civic/community. The highest priority areas of need were the focus for the initial planning process by the Wraparound team.

Goal attainment A review of the final Wraparound plan by the facilitator found goal attainment ratings of Met (M) or Partially Met (PM) in the top six domain areas as follows: health/mental health/recovery 85.9 %, legal 91.3 %, family relations 90 %, financial/income 79.2 %, housing 80.6 %, and education/training 71 %. Examples of attainment of health goals included staying in recovery and having a healthy baby. Goals in the legal domain were compliance with court orders or probation requirements. Family relationship goals included reconciling relationships and having custody of their child.

Child welfare involvement There was no difference in child welfare involvement or child removal between the groups. At the time, baseline data were collected on the Study Child at 3 months of age, 40.6 % of all families had child welfare involvement since the child's birth (40 % Wraparound/41.2 % Standard Care), and the infant was removed in 23 % of families (27.6 % Wraparound/17.6 % Standard Care). Removal of the Study Child by 12-month postpartum was 29.6 % for the sample (31.6 % Wraparound/27.3 % Standard Care), with one out of four families continuing their involvement with child welfare (26.3 % Wraparound/24.3 % Standard Care).

Statistical Findings The randomized two-group design of the study tested the hypothesis that a Wraparound intervention would result in better recovery outcomes for pregnant and postpartum women in substance use treatment compared to standard treatment alone. A MANOVA was used to compare outcomes between the two study groups. An alpha level of 0.05 for all statistical tests was used. Significant multivariate effects were found for outcomes in mental health, family functioning, and natural supports. The three measures used to determine mental health outcomes were the Addiction Severity Index (ASI)—Lite version, the Brief Symptom Inventory (BSI), and the Post-traumatic Diagnostic Scale (PDS). Family functioning was measured using the Self-Report Family Inventory (SFI), and the

availability of natural supports for parenting, finances, and recovery was measured by study-developed items.

Addiction Severity Index—Lite (ASI) No difference was found between groups in the reduction of substance use on the ASI Drug Use subscale. Both groups showed significant reduction in substance use at 12-month postpartum ($p < 0.001$). The ASI Psychiatric Subscale showed statistically significant differences in reduction of mental health symptoms in the Wraparound group ($p = 0.043$).

Brief Symptom Inventory (BSI) No significant difference between groups was found on the BSI. The trend line showed the Wraparound group reporting fewer symptoms and the standard care group reporting more symptoms at 12-month postpartum.

Post-traumatic Diagnostic Scale (PDS) No statistically significant difference between groups was found at baseline or at 12-month postpartum on the PDS. At baseline 78.6 % of total sample met criteria for lifetime trauma exposure with 40.5 % meeting PTSD diagnostic criteria. The Wraparound group had slightly higher trauma symptoms at baseline in both symptom severity and level of impaired functioning related to symptoms. At post, the trend line indicated somewhat less severe symptoms in the Wraparound group and slightly lower level of impaired functioning than the standard care group.

Self-report Family Inventory The Wraparound group showed better family functioning than the standard care group in the SFI Total Score ($p = 0.012$). The Wraparound group was lower on the family Conflict subscale ($p = 0.006$) and higher on the overall Health subscale ($p = 0.023$).

Natural Supports The Wraparound group approached significance in more natural supports for recovery ($p = 0.051$). No statistical difference between groups was found in financial or parenting support.

Discussion of Significant Findings

The Wraparound intervention with mothers in early recovery from substance use resulted in better outcomes in three areas when compared to standard treatment alone: fewer mental health symptoms, improved family functioning, and more natural supports. Each of these outcomes are positively associated with sustaining recovery from substance use after treatment and suggests that Wraparound as a systems of care approach may benefit this population.

Improved Mental Health An assumption made as the study began was that there were existing linkages between the substance use treatment programs and the community mental health services. Descriptive data collected on all participants at pre- and post-time points from the background information form (BIF), however, showed limited utilization of mental health services in both groups with a slight

increase at post. At baseline, 7.3 % of the standard care group was utilizing mental health services compared with 11.6 % of the Wraparound group. Both groups showed an increase in utilization of mental health services at 12-month postpartum at 23.3 and 26.5 %, respectively.

The data confirm observations made during the implementation of Wraparound that numerous barriers existed to accessing the community mental health system even with direct facilitation efforts of the team. The limited utilization of formal mental health treatment within the Wraparound group suggests the better mental health outcomes are attributable to the additional supports available to them through the team process. The better mental health outcomes are also consistent with other research on the positive benefits of support to both mental health and sustained recovery.

The lack of significant improvement in trauma symptoms is both revealing and concerning. The concern is that trauma symptoms can contribute to relapse if not fully recognized and addressed as a co-occurring condition through the substance use treatment program. In early recovery as reliance on a substance that may have covered uncomfortable emotions is eliminated, the emergence of trauma symptoms should be re-assessed as part of treatment progression. The persistence of trauma symptoms at 12-month postpartum for mothers who have participated in substance use treatment suggests the services and supports for this aspect of their mental health needs was not adequate and should be of concern to all service providers. Responses to the PDS trauma measure indicated that women considered the removal of a child by welfare authorities a traumatic event. Some participants experienced removal of a newborn during the study, and some the removal of children in the past.

Family Functioning Family relationships were a priority for Wraparound participants and the goals related to family were met or partially met to a large degree as reflected in the Wraparound plans. Specific outreach by the Wraparound facilitators to invite and include family members in the team process were at times challenging but also provided a structured and measured way for family to participate in the recovery process and provide support. This provided an opportunity for reconciliation in relationships, especially when conflicts were related to the woman's substance use and she was able to demonstrate her continued recovery. Welcoming a new family member with the birth of a baby also contributed to the motivation to resolve family issues.

Natural Supports In the study, the composition of the Wraparound teams included 45.4 % natural supports and 54.6 % professional supports; the preferred practice standard is for natural supports to comprise two-thirds of team membership and professional supports one-third. The lower proportion of natural supports on the wraparound teams in the study reflects the often estranged relationships women experience associated with substance use in families and the need to rebuild a social network supportive of recovery. Other research has found that mental health problems, family conflict, and lack of supports all contribute to relapse and resumption of substance use.

Practice Implications: Wraparound with Low-income Mothers in Recovery

Effective interventions for families with young children require an accurate understanding of the realities of their lives. When working with mothers in recovery who have young children, such an understanding should include knowledge of the woman's trauma experiences and the associated mental health and substance use problems. With low-income mothers, understanding the impact of their lack of income and limited resources available to them in addressing their needs and the needs of their family is also critical. Treatment programs for pregnant and postpartum women collaborate with multiple systems to access the comprehensive array of services low-income mothers and their families need; however, barriers to such collaboration become barriers to optimal outcomes for women in sustaining their recovery (Werner et al. 2007). As demonstrated in the Strong Start Study, Wraparound can provide a mechanism for facilitating a collaborative process of service delivery to support healthy family functioning that goes beyond the scope of traditional case management and may involve the continuation of services after formal substance use treatment is completed. The additional benefit of the Wraparound process is in helping low-income mothers develop social and institutional connections to access resources within their community to sustain their recovery process.

Wraparound as a Systems of Care Practice Model The use of a High Fidelity Wraparound intervention with women in early recovery as described in this chapter is the first known application of a system of care approach in addressing the complex behavioral health needs of this population of mothers and their children.

Nationally, Wraparound has become the recognized practice model in fulfilling the intent of system of care in addressing complex behavioral health needs of children, youth, and families. The intention is to address the multiple needs associated with the behavioral health care of a population in a systematic and efficient way, guided by value-based principles on how services will be provided. The participating systems must have an investment in working collaboratively as well as a commitment to the shared philosophy of serving families to facilitate effectively across multiple agencies and providers. (Bruns et al. 2010). An adapted definition for Wraparound system of care with this population is proposed as

> A Wraparound system of care approach for low-income women in early recovery from substance use who are parenting young children facilitates collaboration between and among…a spectrum of effective, community-based services and supports…that is organized into a coordinated network to build meaningful partnerships with families in a culturally relevant context in order to help them function better at home, in the community, and throughout life (adapted from Stroul et al. 2010).

The essential element of Wraparound in a system of care practice is the team, comprised of professionals providing services to the family, and family members and friends who are natural supports. The dynamics of the team process has been

examined from a theoretical perspective as the "black box" of what makes the Wraparound approach work (Bertram and Bertram 2003). Team development in Wraparound is critical to a meaningful planning process and the associated successful outcomes. With attention to selection, preparation, and contribution of members—both professionals and natural supports—the Wraparound team can function as a mechanism for the ecological systems theory in practice (Bertram and Bertram 2003). This happens with representative team members from multiple systems who have some authority regarding the services available to address the identified needs of the family and the funding to provide those services. Team members who are family or friends represent the most intimate relationships within the ecological system and provide the important, lifelong social support needed to sustain recovery and general well-being.

Recovery: Restoring Physical, Mental, and Social Health The field of addiction medicine in the USA addresses concerns about drug use and how best to treat the problem. When a psychological or physical dependence on a substance develops, the result is impairment in day-to-day functioning. When functioning becomes significantly impaired, a person may voluntarily seek treatment for substance use, or be referred for treatment by another source. Traditional treatment has been provided through an "acute care" model to stabilize a person short term as they withdraw from their substance use and return to a more functional level in their lives. From this perspective, one treatment episode would result in a cure for substance use followed by lifelong abstinence, perhaps with reliance on a 12-step program for ongoing support.

A paradigm shift has occurred, however, in addiction medicine. Dependence on alcohol and other drugs is now being viewed as a chronic condition characterized by "recurrent cycles of relapse and recovery" (Dennis and Scott 2007). This change in perception has resulted in approaches that focus on sustaining recovery and understanding ways to support the recovery process over time (El-Guebaly 2012; White 2009). The longer view of the time required for a change in substance use behavior is reflected in the current definition of recovery by the American Society of Addiction Medicine (ASAM) as "a process of sustained action that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction" (2013).

Defining Health Sustained recovery from addiction to alcohol and other drugs is highly individualized and influenced by a person's level of functioning when the substance use problem began, and the resources available to them during their recovery. This is especially relevant when considering the overall physical, mental, and social health status of low-income mothers in recovery. Health, as defined by the National Institutes of Health in the USA, is based on evidence of (1) physical functioning without disease or symptoms of impairment, (2) cognitive and psychological (mental) functioning without evidence of symptoms of emotional distress, and (3) capacity for social interaction with others and participation in role functioning within the family, work, or school environment (Reeve 2007 as reported in El-Guebaly 2012). By these criteria, recovery involves not only

restoration to a level of functioning before a substance use problem began, but improvements in physical, mental, and social functioning to higher levels than the woman had known before (Laudet and White 2008).

Early Recovery Recovery from substance use requires time in making significant life changes. Progressive phases of recovery are recognized in the field as *early recovery* during the first year, *sustained recovery* from one to five years, and *stable recovery* after five years (adapted from The Betty Ford Institute Consensus Panel 2007). As reflected in the priority needs of mothers in the Strong Start Study, the most important goal during the first year of recovery is recovery. This is possible when there are adequate resources for meeting basic needs of the family for stability and security, and when there are sufficient social supports to buffer ongoing stresses and help with coping. Sustained recovery over time requires ongoing available resources, both internal and external, that support recovery long term by meeting the changing needs of both the woman and her child (Laudet and White 2008). This makes the community a critically important factor for families in recovery as it is the environment where access to local resources will either support or detract from the recovery process (White 2009).

Social Capital Becomes Recovery Capital Resources needed for recovery are essentially resources needed for life. The term "capital" can be understood as assets or resources; *social capital* implies that relationships with others facilitate the access needed to resources. Conceptually, social capital emerged from diverse theoretical lenses, including sociology, psychology, and political science (Overcamp-Martini 2007). As discussed here, the sociological perspective on social capital is used.

The types of resources within the physical and social environment in which a family lives and the quantity and quality of those resources are reflected in their level of social capital and, to a great degree, the options available to them. The key aspect of social capital relevant to low-income families in recovery is the importance of social relationships at the individual, community, and institutional levels in facilitating access to resources (Hawkins and Maurer 2012). As important for low-income mothers and their children are existing structural barriers that prevent access to resources, and ways a team-based Wraparound approach can help families build social capital by reducing those barriers through both informal supports and formal social services (Parcel and Pennell 2012).

Recovery capital In 1999, researchers from sociology and social work introduced the construct of "recovery capital" into the substance abuse and addiction literature as a way of understanding how social capital in its various forms can provide the resources needed to change substance use behavior (Granfield and Cloud 1999). The construct of recovery capital came from research with people who had significant substance use problems and were able to overcome them without formal treatment. However, this phenomenon of quitting a dependency on or addictive use of a substance without professional help has been documented in the research literature for many years under various terms indicating a path found to "natural

recovery" (Granfield and Cloud 2001). As a group, people who initiated and sustained their recovery identified aspects of their lives that allowed them to change their substance use behavior when it became problematic. The key factors that enabled their recovery were their personal characteristics, their environment, and the resources available to them (Cloud and Granfield 2008). Collectively these common factors represent recovery capital and its definition as "the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery" from substance use problems (Granfield and Cloud 1999).

Drawing from the types of social capital identified by others that can become recovery capital considered here are personal, relational, and communal (adapted from Granfield and Cloud 1999; White and Cloud 2008). *Personal capital* encompasses the physical and mental health of the individual, the tangible assets including income, housing, transportation, education, or vocational training, as well the intangible assets of meaning and purpose in life, interpersonal and problem-solving skills, self-awareness, and self-efficacy. *Relational capital* includes positive social networks with family, friends, and significant others as well as established connections with institutions such as school, work, church, and community (White and Cloud 2008). *Communal capital* is shared with others in the local environment and within the society in the form of public space and accommodations, access to natural resources, policies assuring safety, and assistance when needed.

Personal capital Participants in the research on natural recovery were individuals from the middle and upper-middle classes. Those participants had available social capital they amassed through education, employment, housing and transportation, and other resources convertible into opportunities and options in recovery. The less tangible personal capital they accessed was in the form of their self-efficacy in being successful in their efforts, problem-solving abilities, and support for their recovery from family and friends.

By contrast, low-income women in recovery typically lack both internal and external resources to draw upon to support recovery. The significant co-occurring mental health conditions impair their cognitive abilities to plan and problem-solve, and can impair their capacity to respond to their children, especially for mothers with trauma experience. The Wraparound team-based process can provide both structure and support to identify priority needs, brainstorm possible resources, and ways to address those needs, and develop a specific plan that can be monitored and adjusted as need. As the results from the Strong Start Study suggest, women who participated in Wraparound reported fewer mental health symptoms, most without formal treatment. Such improvement in mental health functioning can be attributed to the additional support available through the Wraparound team and considered a gain in personal capital as it becomes an asset to be used in recovery.

Relational capital Conflict with family members as well as substance use by family members can limit the potential support they can provide. This was evident in the challenges faced in engagement with family as members of the Wraparound team. The structure and strengths-based approach allowed family members who did

participate a way to understand the woman's needs in recovery and to offer their support in specific ways. The findings from the study of improved family functioning and less conflict suggest a gain in relational capital. Gains in this type of social capital through the support from positive relationships that buffer stress are considered protective factors for mental health and recovery (Moos and Moos, 2007; Overcamp-Martini 2007).

Communal capital Within the framework of social capital, publicly funded substance use treatment programs accessible by low-income women is a resource for recovery reflective of communal capital. In this regard, Granfield and Cloud argue

> …the principal function of most treatment is to actually provide or help people create their own recovery capital…effective treatment produces and expands recovery capital (1999).

The benefit derived from comprehensive treatment programs designed for pregnant and postpartum women that are intended to address their complex needs help them increase their recovery capital by accessing resources. When pregnant women begin recovery with multiple needs, limited income, and co-occurring mental health conditions, the treatment program should be long enough for them to stabilize with their infant and have sufficient recovery capital to move forward successfully.

Communal capital is evident in the official recognition of the important role of community and local resources to sustained recovery. With the support of SAMHSA, the concept of Recovery-Oriented Systems of Care (ROSC) emerged in 2005 as an ecological model for addressing recovery needs comprehensively at the local level (Sheedy and Whitter 2009). As a way of advancing the goals of ROSC, Wraparound as a systems of care practice model can facilitate access to resources to strengthen the recovery process for a mother and her family in their community.

Building Recovery Capital Through Wraparound Social capital can belong to an individual or the community (Overcamp-Martini 2007). When a community has sufficient social capital, it can fulfill the functions of supporting the growth of its members, regulating the distribution of goods and services, and facilitating inclusion and socialization (Ungar 2011). Communities lacking concrete resources rely more on the "bonding" form of relational social capital that comes through the attachment within families and other close personal relationships that help people get by day-to-day (Overcamp-Martini 2007). These informal relationships can become important social supports for recovery as members of a Wraparound team. Another form of social capital known as "bridging" occurs when the relationship is with someone with access to services or systems beyond the local community that can help people get ahead (Overcamp-Martini 2007). The structure and process of the team-based Wraparound approach provide bridging capital as members offer ways to negotiate multiple service systems and utilize the formal, professional supports in developing and coordinating the resources needed for better family outcomes (Parcel and Pennell 2012; Ungar 2011).

The framework of developing recovery capital through substance use treatment is consistent with the current standards in place for specialized treatment programs

for pregnant and postpartum women that recognize the comprehensive needs that must be addressed to enable recovery and support adequate functioning in the parenting role. The Wraparound process is especially well-suited to provide the facilitated collaboration needed with multiple service delivery systems and providers to increase women's access to resources, both tangible and intangible, that are essential to the stability needed for themselves and their children. The amount and quality of those resources will become the recovery capital needed to sustain their behavior in living without substance use (Granfield and Cloud 2001).

Policy Considerations: Advancing an Ecological Agenda

From an ecological perspective, the formal linkage between larger social systems at the societal level, and services available at the community level, is policy. Often federal policy must be adopted through state policy to access public funding for programs and services implemented within smaller, more local government agencies, such as counties, or through contracts with nonprofit organizations at the community level. This is how federal social policy, and the funding attached to it, becomes an important source of communal capital for all low-income families and especially for parents in recovery with young children. For parents with substance use disorders and their young children, the systems-level policies that fund services for them and determine how services are implemented involve behavioral health, child welfare, and education. Successful implementation of High Fidelity Wraparound systems of care with families in recovery would involve formal agreements and established working relationships with programs delivering services to them.

Behavioral Health Policy Behavioral health is the integrated system for mental health and substance use treatment. Since the enactment of the Affordable Care Act (ACA), states have begun reorganization of the two systems that have historically operated separately. Federal funding for behavioral health treatment comes to the states through SAMHSA block grants that the state then contracts with behavioral health organizations to provide the direct service in the community. The funds are capitated based on population so access to treatment is limited unless the state designates other funding to supplement the need for services. Most women in the study did not meet the criteria for community mental health services because they were not considered to have serious or persistent mental illness, nor were they eligible for treatment with their infant unless they met the adult diagnostic criteria.

Publicly funded treatment for substance use disorders through SAMHSA has historically had a set aside in the state block grant for pregnant and postpartum women as a priority population. However, with the passage of the ACA and the expansion of Medicaid, the set aside will no longer be in place. There are recommended standards for women's treatment that were developed through the National Association of State Alcohol and Drug Abuse Directors; however, the

adoption of the standards by women's treatment programs is voluntary (Mandell and Werner 2008). Neither are there national standards related to the level of treatment, i.e., outpatient or residential, for pregnant and postpartum women, although residential programs with both the mother and her child for six months or longer provide the structure and stability needed during early recovery.

Child Welfare Policy Federal child welfare policy is established through the Child Abuse Prevention and Treatment Act (CAPTA) that sets forth the requirements of the State Plan to allow a state to receive federal funds. The Adoption and Safe Families Act (ASFA) of 1997 amended CAPTA by limiting the length of time a young child aged 5 and under could remain in out of home placement. Known as Expedited Permanency Planning (EPP), the intent was to assure that young children benefited from the stability of permanency with an adoptive family if their own parents were unable to protect them. The state where this study was conducted had a 12-month timeframe for reunification with the parent or parental rights could be terminated; allowances can be made with court approval for an extension of time when there is evidence the parent is progressing in their recovery.

Research evidence shows better outcomes for mothers and their infants who participate in substance use treatment, federal child welfare policy that assured available residential treatment could be an alternative to out of home placement of newborns. Such policy could provide the safety and stability needed by both the mother and her child as well as providing a better opportunity for bonding and attachment. When the child remains with the parent in treatment, EPP is not a factor and therefore fewer families are subjected to the legal termination of rights. As research has found, women have subsequent children when their infant is removed, and the second child is at increased risk of prenatal substance exposure if the mother is not engaged in treatment.

Education Policy Federal education policy through the Individuals with Disabilities Education Act requires states provide early intervention services for infants and toddlers with developmental delays or disabilities and establishes categorical conditions for eligibility. States can expand eligibility criteria beyond those conditions established by federal policy and fund coverage for additional at-risk children needing services. The intent of early intervention is to identify and mediate developmental delays or disabilities that can interfere with lifelong learning and daily functioning. For young children who have experienced prenatal exposure and meet Part C eligibility, early intervention services can support both the child and parent in addressing developmental concerns. When delays or disabilities that impact learning continue to age 3, Part C will facilitate a transition to Part B for any ongoing special education needs through the local school district.

In addition to Part C, families in recovery with young children are good candidates for Early Head Start programs in their communities. Enrollment begins with infants, and most programs include a service component with the parent. Federal policy to sustain and expand funding for Early Head Start programs could add

significantly to the communal capital available to families, especially when there is a transition to Head Start and the opportunity for children to engage in learning to facilitate school readiness.

Social Policy from an Ecological Perspective The study of biological organisms and their environments in the 1970s informed the application of ecological concepts to human development and the social and physical environments of young children and families (Bronfenbrenner 1977). In the field of social work, the ecological perspective in understanding human behavior and the social environment (Germain 1979) is foundational knowledge and informs current practice with families of young children. Ecological theory's conceptualization of the family as the earliest social environment for young human beings and their development (Bronfenbrenner 1977) fits well with social work's systems perspective of helping individuals and families while also improving the larger environments impacting their lives at the community and societal levels. Informing and influencing social policy is therefore an important area of practice toward that end.

Bronfenbrenner believed that social policy should be informed by the knowledge of human need and the environmental conditions necessary in meeting that need. To advance this ecological perspective, he underscored the need for researchers and practitioners to extend their roles to advocating for the development and enactment of family policy designed to utilize the "…unrealized potential of ecologies that sustain and strengthen constructive processes in society, the family, and the self" (Bronfenbrenner 1986). This need is greatest with families that are the most vulnerable. Low-income mothers in recovery and their families are themselves living on the margins of society and have virtually no influence on policies that impact their daily lives. Based on the knowledge of their experiences, social work and other disciplines can advocate on their behalf for social policies that contribute to their well-being and ensure optimal development for both parents and children.

Conclusion

Low-income mothers in early recovery from substance use have significant co-occurring mental health conditions and can benefit from a Wraparound system of care approach in addressing their complex behavioral health needs. The Wraparound process can add to the social capital needed for recovery by engaging additional supports and facilitating access to resources. The Strong Start Study demonstrated better outcomes in mental health, family functioning, and social supports for mothers who participated in Wraparound, all positive indicators for sustaining recovery from substance use and better role functioning needed in parenting young children.

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Building Young Children's Social–Emotional Competence at Home and in Early Care and Education Settings

Charlyn Harper Browne and Cheri J. Shapiro

Background

The emphasis on cultivating young children's cognitive development in order to foster school readiness has long overshadowed the importance of early social–emotional development (National Scientific Council on the Developing Child 2004a). However, studies have shown that children's social–emotional development is as important for school readiness and success as cognitive and academic preparedness (Webster-Stratton and Reid 2004). Children who have poor social–emotional competencies—such as, "difficulty paying attention, following teacher directions, getting along with others, and controlling negative emotions—do less well in school. They are more likely to be rejected by classmates and to get less positive feedback from teachers" (Webster-Stratton and Reid 2004, p. 96). Shonkoff and Richmond (2009) asserted that social, emotional, and cognitive developmental changes are not independent; rather, they are inextricably connected and coordinated across the life span. For example, research has consistently demonstrated that acquiring social–emotional competence is an essential developmental task of early childhood because it lays the foundation for later cognitive and language development (Brazelton and Greenspan 2000; Center on the Developing Child at Harvard University 2011).

Social–emotional development provides young children with a sense of who they are; helps them to establish quality relationships, interact effectively with others, and resolve conflicts; enables them to use language and communicate adeptly; prepares young children to adapt in school; and empowers them to be

C. Harper Browne (✉)
Center for the Study of Social Policy, Washington, DC, USA
e-mail: charlyn.harperbrowne@cssp.org

C.J. Shapiro
Institute for Families in Society, College of Social Work, University of South Carolina, Columbia, SC, USA
e-mail: cshapiro@mailbox.sc.edu

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self-confident, trusting, empathic, and intellectually inquisitive (National Scientific Council on the Developing Child 2004a; Parlakian 2003). "Building a strong social–emotional foundation as a child will help the child thrive and obtain happiness in life. They will be better equipped to handle stress and persevere through difficult times in their lives as an adult" (Mid-State Central Early Childhood Direction Center of Syracuse University 2009 p. 1).

The Importance of Healthy Relationships, Environments, and Experiences

Studies have found that young children need to have a relationship with a caring, attuned, responsive parent (or other significant adult caregiver) who provides growth-promoting environments and experiences, in order to build a strong social–emotional foundation and achieve positive outcomes in other developmental domains, including healthy brain development (Center on the Developing Child at Harvard University n.d.; National Research Council and Institute of Medicine 2000; Shonkoff and Garner, Shonkoff et al. 2012; Thompson 2001). For example, the National Scientific Council on the Developing Child 2004a) concluded "emotional development is actually built into the architecture of young children's brains in response to their individual personal experiences and the influences of the environments in which they live" (p. 1). Collectively, the essential relationships, opportunities, contexts, and experiences which contribute to healthy development that have been identified in many studies include the following (Harper Browne 2014, p. 37):

1. Parents and other adult caregivers whose social and emotional competence is well developed
2. A warm, nurturing, and trusting relationship with at least one parent or other adult caregiver
3. Intentional actions of parents or other adult caregivers designed to promote social and emotional competence (e.g., modeling skills; practicing skills with the child)
4. Consistent, affectionate, sensitive, and responsive care and interaction with parents and other adult caregivers
5. The positive and encouraging messages communicated to children—directly or indirectly—about themselves
6. Regular and predictable routines
7. A physically and emotionally safe environment that provides for basic physiological needs, protects children from harm, or mitigates the effects of adversity
8. An interactive language-rich environment that promotes vocabulary development, talking, and reading, and encourages children to express their emotions
9. An environment that encourages developmentally appropriate play and opportunities to explore and to learn by doing.

The National Scientific Council on the Developing Child (2004b) reported that healthy parent–child relationships are associated with more well-developed cognitive skills, social competence, cooperative interactions with others, and insights into other people's feelings, needs, and thoughts. In addition, the American Academy of Pediatrics (n.d.) described the importance of healthy parent–child relationships with respect to young children's early brain development. "No aspect of the child's environment is more important for proper brain development than his or her connections with others…. Nurturing and supportive social connections early in life promote healthy emotional regulation and allow for optimal brain development and function" (p. 5).

In contrast, environments that are unsafe, unstable, low in stimulation, or are language-poor—or care that is inconsistent, unresponsive, abusive, neglectful, or rejecting—can disrupt early brain development. "Excessive or prolonged stress in absence of social supports activates and strengthens the neuronal connections underlying the stress response, setting up a brain that is wired more for stress and survival and less for learning and empathy" (American Academy of Pediatrics n.d., p. 5). These life circumstances and resulting underdeveloped early brain architecture are associated with poor social–emotional, cognitive, physical, and behavioral outcomes such as limited language and cognitive skills, difficulties interacting effectively with peers, insecure attachments, developmental delays, behavioral and mental health problems, and numerous health problems and conditions later in life (Center on the Developing Child at Harvard University 2010, 2011; Felitti 2002; Stark and Chazan-Cohen 2012). Thus, a child's relationships, environments, and experiences can literally strengthen or inhibit the neural connections and pathways that are forming within the young brain and that facilitate later brain functioning, learning, development, and behavior.

In focusing specifically on early unmet social–emotional developmental needs, Cooper et al. (2009) found that in the USA: (a) between 9.5 and 14.2 % of children birth—5 years old experience social–emotional problems, and (b) almost 40 % of 2-year-olds in early care and education settings had insecure attachment relationships with their mothers. These data suggest that promoting social–emotional competence should be a priority for parents and those who work with young children and their families (Boyd et al. 2005; Cooper et al. 2009; National Scientific Council on the Developing Child 2004b; Raver 2002). This need is elevated when serving young children and their families who are experiencing adverse conditions. Early childhood is a period of heightened vulnerability to toxic environments and experiences. But early childhood is also a period of great opportunity to prevent or mitigate the effects of adversity and re-direct young children's developmental trajectory toward more positive outcomes by intentionally and purposefully building social–emotional competence (Brazelton and Greenspan 2000; National Research Council and Institute of Medicine 2000).

Social–Emotional Competence

Social–emotional competence can be conceived as four interrelated and essential abilities—social cognition, self-awareness, executive function, and self-regulation—that enable children to do the following: (a) experience, identify, express, understand, and regulate their own feelings in a constructive manner; (b) accurately read, understand, and feel empathy for others' emotions; (c) establish and sustain positive relationships with peers and adults; (d) explore the environment and learn; (e) set and achieve positive goals; and (f) make productive decisions (CASEL Guide 2012; National Scientific Council on the Developing Child 2004a). A description of the four abilities and their components follows.

Social Cognition and Self-awareness

Social cognition enables individuals to function successfully in the social world. More specifically, social cognition refers to the ability to do the following: (a) take the perspective of and empathize with another person's point of view; (b) understand how and why people act and feel as they do; (c) understand, accept, and value differences in others; and (d) appreciate the importance of social and ethical norms for behavior (Beer and Ochsner 2006; Sommerville 2011; Zelazo 2011). Research has shown that the development of strong social cognition is related to better communication skills, positive ratings by peers, academic success, and high-quality interpersonal relationships (Zelazo 2011). In contrast, children with poor social cognition "are more likely to have difficulty making the transition to school…and to experience difficulties in school that may be misread as conduct problems (e.g., lacking respect toward a teacher)" (Zelazo 2011, p. i)

In concert with the development of social cognition is the development of self-awareness, that is, the ability to recognize and assign value to one's thoughts and emotions, and to understand their influence on behavior (CASEL Guide 2012). Young children's self-awareness, self-understanding, and self-worth are "highly dependent on the evaluation of others…especially those to whom the child is emotionally attached" (Thompson 2001, p. 27). Young children's sense of self is also related to being securely or insecurely attached to a parent. In an examination of the relationship between preschool children's attachment status and self-characteristics, Sroufe et al. (2005) found that children with insecure attachment histories demonstrated less self-reliance and were rated low on self-esteem by teachers. In contrast, children with histories of secure attachment were the highest rated on self-esteem and self-confidence.

Table 1 Social cognition and self-awareness competencies

	Aspect	Definition
1	Empathy	Understanding and responding to the emotions and rights of others
2	Personal agency	Taking responsibility for one's self and one's decisions and having confidence to overcome obstacles
3	Perspective taking	Taking the viewpoint—thoughts, beliefs, or feelings—of another person
4	Self-compassion	Being kind to oneself when confronted with personal failings and suffering
5	Self-concept	Stable ideas about oneself
6	Self-confidence	Being open to new challenges and willing to explore new environments
7	Self-efficacy	Having realistic beliefs about one's capabilities
8	Self-esteem	Feelings about oneself
9	Social skills	Making friends and getting along with others
10	Theory of mind	Thinking about the beliefs, desires, and intentions of others

Harper Browne (2014, p. 41) provided a summary of social cognition and self-awareness competencies, synthesized from several research studies; see Table 1.

Executive Function and Self-regulation

The Center on the Developing Child at Harvard University (2016) defines executive function and self-regulation as integrated "mental processes that enable us to plan, focus attention, remember instructions, and juggle multiple tasks successfully…. The brain needs this skill set to filter distractions, prioritize tasks, set and achieve goals, and control impulses" (para. 1). Masten et al. (2008) reported that the mental processes that are a characteristic of executive function and self-regulation are essential skills for school readiness, learning, and early school success, in that they include "skills to direct attention, ignore distractions, control impulses, follow rules, and also flexibly adapt to rule changes….Research has indicated that these 'tools of the mind' are particularly important for high-risk children, and also that stressful early experiences might disrupt their development" (p. 5).

Overall, executive function and self-regulation are key ingredients for optimal development, productivity, and successful performance across the life span (Harper Browne 2014, p. 42) provided a list of executive function and self-regulation mental processes that begin to emerge in an early childhood and continue to develop in adolescence and adulthood; see Table 2.

Table 2 Executive function and self-regulation skills

Skill	Definition
Behavioral self-regulation	Staying on task even in the face of distractions
Cognitive self-regulation	Exercising control over thinking; planning and thinking ahead; making adjustments as necessary; identifying and challenging unhealthy thinking
Communication skills	Understanding and expressing a range of positive and negative emotions
Conflict resolution	Resolving disagreements in a peaceful way
Consequential thinking	Considering the outcomes of one's thoughts, feelings, and actions before acting
Emotional control	Modulating emotional responses by bringing rational thought to bear on feelings
Initiation	Beginning a task or activity and independently generating ideas, responses, or problem-solving strategies
Patience	Learning to wait
Persistence	Willingness to try again when first attempts are not successful
Planning and organization	Having a goal and using reasoning to achieve it; the ability to manage current and future-oriented task demands; imposing order
Problem solving	Understanding what is needed to solve the problem; developing and executing a plan; evaluating the adequacy of the attempted solution
Prospective memory	Holding in mind an intention to carry out an action at a future time
Selective attention	Focusing on a particular object, while simultaneously ignoring irrelevant information that is also occurring
Self-monitoring	Monitoring one's own performance and measuring it against some standard of what is needed or expected
Self-talk	Reflecting; instructing oneself; self-questioning
Social–emotional self-regulation	Exercising control over reactions to positive and negative situations; delaying gratification; labeling one's and others' emotions accurately; expressing emotions in healthy ways; taking ownership of emotions
Visual imagery	Imagining the image of attaining one's goal

Executive Function, Self-regulation, and Brain Function

The Center on the Developing Child at Harvard University (2016) identified three interrelated and coordinated brain functions that support executive function and self-regulation mental processes: working memory, mental flexibility, and inhibitory control.

- **Working memory** controls the ability to follow instructions sequentially and retain information over short periods of time while engaging in another activity.
- **Mental flexibility** facilitates the ability to see alternate solutions to problems, shift perspective, move from one situation to another, and apply different rules in different settings.
- **Inhibitory control** enables the ability to resist or stop impulsive thoughts, actions, or responses at the appropriate time.

Children are born with the potential to develop these brain functions and executive function and self-regulation mental processes. But, like other aspects of social–emotional development, the quality of young children's relationships, environments, and experiences can either strengthen or undermine the development of brain functions and executive function and self-regulation mental processes (American Academy of Pediatrics n.d.; Center on the Developing Child at Harvard University 2011, 2016). Thus, as abilities are learned, young children must have opportunities and experiences that enable them to practice these skills, both at home and in early care and education settings. "Generally, if children do not practice deliberate and purposeful behaviors, traces in the brain are not reinforced ('use it or lose it' principle). So, if preschoolers do not practice self-regulation enough, the related brain areas will not be fully developed" (Boyd et al. 2005, p. 4).

Facilitating Social and Emotional Competence at Home and in ECE Settings

As noted thus far, promoting children's social and emotional competence relies on strong, supportive adults who can provide safe, stable, and nurturing environments and the opportunity to practice emerging self-regulatory skills. The first and most important environment for the development of young children is the home. The home environment is shaped by parents and primary caregivers and is strongly dependent on the ability of these adults to effectively manage and support their own functioning. Without these skills, adults will be less able to manage the tasks of supporting child development and raising competent, confident children.

Importance of Parent Self-regulation

Raising children is facilitated by parents who have their own basic needs met. Parents and caregivers who have stable housing, adequate nutrition, social support, and the ability to find fulfillment are arguably in a stronger position to respond in the best manner possible to their children. Indeed, having a warm, emotionally responsive environment is critical for infant attachment and lays the foundation for the development of self-regulation (Easterbrooks and Biringen 2009). Parent self-regulation, or the capacity to alter parenting behavior in response to their child's needs and behaviors, can be thought of as one of the most important skills parents need to possess to be effective as a parent (Sanders and Mazzucchelli 2013). Furthermore, enhancement of parent self-regulation is conceptualized as the foundation for the development of child self-regulation; parents who have the ability to regulate their own behavior are in a position to most consistently respond to their children in ways that can promote the children's positive development (Sanders

2008; Sanders and Kirby 2014; Sanders and Mazzucchelli 2013). However, a number of factors can interfere with parent ability to respond in a sensitive, warm, supportive, and deliberate way toward their infants and young children. These include parent challenges with mental illness, substance abuse, domestic violence, and food insecurity; independently or in combination, these challenges represent barriers to parent (and ultimately child) self-regulation.

Parent's own upbringing can influence their own self-regulatory abilities (Sanders and Mazzucchelli 2013). As the seminal research by Felitti and Colleagues regarding the adverse childhood experiences (ACES's) has demonstrated, childhood exposure to family-based challenges such as parental substance abuse, mental illness, domestic violence, or child maltreatment is linked to poor health outcomes for adults; the greater the number of adverse experiences, the larger the impact on health, including premature mortality (Brown et al. 2009; Felitti et al. 1998). Recent research examined ACE's in a sample of children (ages 0–6) who had been involved in the child welfare system. Using data from the National Survey of Child and Adolescent Well-being, a longitudinal study of children involved in the child welfare system, as the number of ACES increased, the risk for later emotional and behavioral problems significantly increased (Freeman 2014). Thus, we have evidence that suggests exposure to family-based adverse experiences can impact child functioning as well as having a deleterious impact on adult health and functioning. Below we examine a select subset of these adverse experiences that can pose barriers to parent, and ultimately child, self-regulation.

Barriers to Parent Self-regulation

Parent Mental Health and Substance Abuse: Prevalence rates of common mental health disorders among adults remain high and can negatively impact parental ability to support child self-regulation. Among mental health disorders, depression is the most common; according to the National Institute of Mental Health, in 2014 6.7 % or 15.7 million adults over age 18 had at least one major depressive episode during the previous year (http://www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adults.shtml). According to a report on parental depression by Child Trends, approximately 1 in 5 children is living in a household with a parent who has experienced severe depression; the rates of depression among single parents are almost double as that compared to two-parent families (54_Parental_Depression1.pdf n.d.). Rates of depression are nearly twice as high among females as compared to males (Major Depression Among Adults n.d.); thus, the potential impact of maternal depression on the development of young children is significant.

As noted by Middleton et al. (2009), parental depression impacts both parenting behaviors and child behavior. Parental depression, along with family income level, has been shown to impact parenting practices and later child attachment, self-regulation, and cognitive outcomes (Nievar et al. 2014, p. 329). Even milder forms of parental depression and anxiety can have a negative impact on children's

ability to regulate their emotions and behavior (West and Newman 2003). Importantly, the relationship between parental symptoms of depression and the development of child behavior problems (both internalizing and externalizing) appears to be reciprocal and bidirectional (Bagner et al. 2013). These findings underscore the need to carefully and simultaneously assess children's behavior, parenting, and parent personal functioning. Fortunately, a range of effective treatments are available for adult depression, including cognitive behavioral therapy, interpersonal therapy, and combined interventions, involving pharmacotherapy with psychosocial treatment approaches, among others (Cuijpers et al. 2013, 2011). Thus, early identification and treatment for parental depression are important for supporting the growth of self-regulation in children.

Importantly, screening for depression should also include screening for other mental health disorders and common co-occurring disorders, including substance abuse. Both parental substance abuse and mental illness have been found to have a negative impact on child behavior as was found in one recent treatment study (Risser et al. 2013). Substance abuse remains a common challenge among adults in the USA. In 2014, 6.4 % of individuals aged 12 and above (approximately 17 million individuals) abused or were dependent on alcohol, and 2.7 % (approximately 7.1 million individuals) abused or were dependent on illicit substances (Behavioral Health Barometer: United States Annual Report 2015–2015_National_Barometer.pdf n.d.). Substance use and dependence can impact parent personal functioning, work performance, interpersonal relationships, and parenting behaviors. Families operate as systems; the impact of a parent with a substance disorder reverberates throughout the system and changes family connections, communication, routines, and functioning (Lander et al. 2013). These disruptions to family functioning can result in children's basic needs not being met and can contribute to child maltreatment (www.childwelfare.gov/pubs/factsheets/subabuse_childmal.cfm).

Support for the notion that parental substance abuse can influence the development of child self-regulatory behaviors comes from studies showing increased vulnerability of children being raised in homes with parents or caregivers who struggle with substance abuse to experience a range of maladaptive outcomes. Children of alcoholic fathers have been shown in one longitudinal study to have lower social competence in kindergarten as compared to children whose parents are not experiencing problems with alcohol (Eiden et al. 2009). Negative impact of parental substance use on children does not end in early childhood; having a parent with an alcohol use disorder (AUD) increases the risk for children to also develop AUD; this risk increases further if both parents have an AUD (Yoon et al. 2013).

Family Domestic Violence: Domestic violence is a prevalent problem that causes major family disruption and even death. According to the National Survey of Children's Exposure to Violence conducted in 2008 (NatSCEV), 6.6 % of children were exposed to intimate partner violence between a parent and partner in the home during the previous year (Hamby et al. 2011). Domestic violence impacts parenting and child development in a number of ways. In a review of the potential pathways by which domestic violence can interfere with child growth and nutrition, Yount

et al. (2011) document multiple pathways for such interference, including dysregulated responses to stress in children (Yount et al. 2011). Children raised in environments with domestic violence can also experience a wide range of problems with anxiety, depression, aggression, and post-traumatic stress (Holt et al. 2008; Mohammad et al. 2014). Over time, toddler's exposure to increasing domestic violence has been found to predict increases in internalizing and externalizing behavior problems and negatively impact school engagement 5–6 years later (Schnurr and Lohman 2013, p. 1027). Evaluation for the presence of interpersonal violence within families of young children is thus an important undertaking if we hope to support children's social and emotional competence in home settings.

Family Food Insecurity: Food insecurity has been receiving increasing attention in the last decade as an important problem for families. The USDA has defined a range of terms related to the degree to which an individual or family has difficulty accessing to food (USDA Economic Research Service—Definitions of Food Security n.d.). To be food insecure, individuals need to report limited access to a range of foods or reduced food intake. In 2012, 14.5 households were classified as food insecure (Coleman-Jensen 2013). Family food insecurity has been linked to a number of child social, emotional, and behavioral challenges, as well as nutritional deficiencies, which can have a significant negative impact on children's physical, cognitive, and social–emotional development (Jacknowitz et al. 2015). However, it is important not to assume that poverty is a proxy for food insecurity. While food insecurity is related to poverty, the majority of poor households are not food insecure (Fram et al. 2014). Thus, an assessment for concerns about provision of adequate nutrition is important to support children's social and emotional competence at home.

Promoting Children's Social and Emotional Competence at Home

Interventions that address the significant barriers to parent well-being and that promote parental self-regulation are necessary to improve outcomes for both parents and children. These include preventive approaches as well as evidence-based interventions for adult depression, substance abuse, domestic violence, and food insecurity. Interventions that support positive parenting are an important avenue for promoting children's social and emotional competence. Evidence-based parenting interventions for parents of young children, including Incredible Years, parent–child interaction therapy, and Triple P, have demonstrated strong impact on child social, emotional, and behavioral functioning (Boggs et al. 2005; Hood and Eyberg 2003; Sanders et al. 2014; Webster-Stratton 2001; Webster-Stratton et al. 2011). Home visitation programs, including Nurse–Family Partnership (NFP) and Parents as Teachers, have also been demonstrated to improve outcomes relevant for child social and emotional competence at the parent and/or child level (Olds 2006; Olds et al. 2015; Zigler et al. 2008; also see Chap. "Promoting Early Childhood Development in the Pediatric Medical Home", this volume).

In addition to structured, evidence-based parenting and home visitation programs, there are a number of activities that parents can engage into promote child social and emotional competence. In terms of activities, having established routines for daily activities provides the structure necessary to support children. Regular interactions, in particular talking with children, can foster social–emotional growth and promote language development, which has been linked to later cognitive and academic functioning (Hart and Risley 1995). Indeed, the ability to communicate one's needs effectively is key to promoting positive coping and eliminating a range of negative behaviors, as noted by the impact of functional communication training on behavior problems in young children (Durand and Moskowitz 2015).

Parents can also play an important role in shaping the development of important aspects of self-regulation of emotions and behavior in children. These can be accomplished by use of behavioral kernels, described by Embry and Colleagues, as basic units of behavior change technology that have empirical support and that appear to be present in effective evidence-based interventions (Embry and Biglan 2008; Rotheram-Borus et al. 2012). Kernels are also well defined and thus can be disseminated easily (Weisz et al. 2011). As noted by Shapiro (2013), examples of kernels include common behavioral strategies, such as verbal descriptive praise, warm greetings, or time-out. Parental use of these strategies, including verbal descriptive praise for encouraging child actions such as using words to describe feelings, managing frustration well, and calming themselves after an upsetting event, can all be used to promote child self-regulation. Use of non-coercive strategies such as time-out to support children's ability to regain emotional or behavioral control is another example. Thus, parents can act in a number of ways throughout their daily interactions to support and nurture child self-regulation.

Promoting Children's Social and Emotional Competence in Early Care and Education Settings

In addition to the home environment, early care and education settings offer powerful opportunities to directly promote child self-regulation. Through interactions with stable, warm early care and education (ECE) providers, children can learn to develop the social and emotional competencies necessary to support optimal child development as well as skills needed for success in school.

Practices Promoting Child Self-regulation

Children's social and emotional development is recognized as a critical part of effective preschool education programs. The Collaborative for Academic, Social, and Emotional Learning (CASEL) is a national organization designed to promote

evidence-based social and emotional learning (SEL) in educational settings (www.casel.org). SEL is defined by CASEL as the process of helping children understand and manage their emotions (self-awareness and self-management), effectively manage developing empathy (social awareness), strengthen peer relationships (relationship skills), and promote responsible decision making (http://www.casel.org/social-and-emotional-learning/core-competencies). CASEL has identified a number of programs that operate in the preschool to early elementary school setting that includes SEL; children are provided opportunities to practices SEL, and programs also work to integrate SEL across contexts beyond the classroom (e.g., school-wide, home, community) (CASEL Guide 2012, p. 20).

Programs Promoting Social–Emotional Competence in Young Children

CASEL has identified programs that focus on promoting social and emotional competence in ECE settings that have been empirically examined in at least one randomized trial for young children (here defined as preschool through grade 1) including HighScope Educational Approach for Preschool, I Can Problem Solve, Incredible Years Series, PATHS, Peaceworks, and Tools of the Mind (CASEL Guide 2012, p. 24). Each of these programs rests on strong adult–child interactions and integrates social and emotional learning with academic learning, all of which support positive child development and school readiness.

HighScope Educational Approach for Preschool is the result of an experimental study conducted in the 1960s in which 123 preschool participants were randomly assigned to intervention or comparison groups (referred to as the HighScope Perry Preschool study, named for the school in these students attended) (Weikart and Schweinhart 1997). The curriculum is characterized by participatory learning and routines, and is grounded in positive adult–child interactions (www.highscope.org). Long-term follow-up of participants continues; in addition to improved intellectual and school achievement outcomes beyond preschool, impacts include adult employment and reductions in adult crime and are believed to be due to the quality of the preschool program and high rates of parent engagement (Schweinhart 2007, 2013; Schweinhart et al. 1985). ECE providers can access information and training in the preschool curriculum at http://www.highscope.org/content.asp?contentid=63.

The "I Can Problem Solve" program is a classroom-based curriculum targeting interpersonal problem solving to reduce disruptive behaviors (Rooney et al. 1993). Lessons are available from preschool through the elementary school years (i.e., children aged 4–12) and are directly implemented in classrooms; as noted earlier in the chapter regarding the critical role of opportunities to practice skills, children then are supported to apply these skills directly in the classroom setting through an approach that shapes these skills (http://www.cebc4cw.org/program/i-can-problem-solve-icps/detailed).

The Incredible Years (IY) series consists of parent, teacher, and child training components, and has been examined in the preschool settings (see Chap. "Promoting Early Childhood Development in the Pediatric Medical Home", this volume, for additional details of the IY series). Brotman et al. (2005) conducted a randomized prevention trial involving group interventions for parents and their preschool-age children at risk for conduct problems (i.e., who had older siblings adjudicated in family court for delinquent acts). Home visits were also incorporated into this prevention approach; improvements include reductions in negative parenting practices as well as improvements in children's social competence (Brotman et al. 2005). IY interventions have also been examined in a large randomized trial with families involved in Head Start; positive outcomes include improvements in parenting, and child behaviors (among parents both with and without a history of child maltreatment) were found (Hurlburt et al. 2013).

PATHS, or Promoting Alternative Thinking Strategies, is an elementary school year age curriculum designed to promote children's social and emotional skills, which has a specific preschool/kindergarten curriculum (PATHS Preschool/Kindergarten; http://www.channing-bete.com/prevention-programs/paths/objectives-goals.html). Teachers implement PATHS in classroom settings. PATHS has been evaluated with elementary school age youth and positive impact on understanding and managing emotions (Greenberg et al. 1995). Results of a randomized controlled trial of PATHS Preschool/Kindergarten conducted in Head Start settings support the efficacy of the curriculum in enhancing children's social competence (Domitrovich et al. 2007). Similar to PATHS, Peace Works for Little Kids was designed to enhance social and emotional skills necessary for conflict resolution among young children (pre-K-grade 2) with lessons administered by preschool teachers in the classroom setting (CASEL Guide 2012, p. 54). Outcomes of one randomized controlled trial in preschool settings included improvements in child behavior and social skills (Pickens 2009). Another classroom-based intervention, Tools of the Mind, is designed to support self-regulatory skills in children in pre-kindergarten and kindergarten, and includes methods to involve parents in promoting these skills at home (CASEL Guide 2012, p. 64).

New ECE programs focusing on the development of children's social and emotional competence continue to emerge. One example is Conscious Discipline (CD).[1] CD is a classroom-based, self-regulation, and behavior management intervention designed to foster social–emotional development within the context of everyday discipline and teacher guidance. The approach centers on safety, the development of interpersonal connections, and social problem solving. CD has a small but growing research base. In 2008, the School District of Osceola County (FL) implemented Conscious Discipline in 20 Voluntary Pre-Kindergarten sites. Students receiving Conscious Discipline had significantly higher levels of protective factors and lower levels of behavioral concerns. The level of Conscious Discipline-training teachers received and the fidelity with which they implemented the program had statistically significant impact on student scores on a measure

[1] www.Consciousdiscipline.com

designed to assess student social and emotional functioning (DECA); reductions in the number of students with at-risk DECA scores were greater for teachers who attended a Summer Institute in addition to CD monthly training compared with teachers receiving only monthly training (Rain 2014).

In summary, there are a number of programs designed specifically to enhance children's social and emotional competence that can be used within the preschool and early elementary school settings. However, the task is not complete. Additional studies are needed to support application of these strategies within ECE settings. Furthermore, while evidence of very long-term impact of the HighScope Educational Approach for Preschool has been demonstrated, long-term follow-up from other programs is needed to determine the specific nature of the impact of early scaffolding of skill development in the social and emotional domains on middle childhood, adolescent, and adult functioning.

Summary and Conclusions

Given the central role that children's social and emotional competence plays in healthy growth and functioning across the life span, it is critical to enhance understanding of how these skills can be developed, promoted, and practiced in both home and early care and education settings. Core social and emotional skills include the ability to self-regulate mood and behavior, establish and maintain relationships, communicate effectively, and feel confident and competent when interacting with the world. To build these skills, a strong foundation is required that includes warm, nurturing, responsive relationships with caregivers whose own needs are met and whose own social and emotional competence is well developed. Opportunities for practicing skills for self-regulation and communication need to occur in a safe, language-rich environment with regular routines and interesting, developmentally appropriate opportunities to play, explore, and learn by doing. Research has demonstrated that current practices and programs in both home and school settings can provide these critical opportunities for promoting children's social and emotional competence. To improve children's health at the population level, future goals include increasing families' access to needed supports and services; expanding the abilities of caregivers to promote children's social and emotional competence; and continued research and development of new and existing programs.

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Promoting Early Childhood Development in the Pediatric Medical Home

John C. Duby

Introduction

Pediatricians have been a source of guidance for families of young children for generations. Recently, the pediatric profession has been challenged to rethink the schedule, content, and structure of well-child care. There is a growing recognition of the need to include a focus on promoting healthy social and emotional development in the context of the parent–child relationship to minimize exposure to toxic stress and reduce the later burden of adult disease. Multiple opportunities exist for expanding the range of services delivered in the pediatric medical home and for strengthening community connections to advance the goal of supporting families to promote early childhood development.

Evolution of the EcoBioDevelopmental Framework

Dr. Julius Richmond, a pediatrician who served as Surgeon General of the USA from 1977 to 1981, received the 1966 C. Anderson Aldrich Award from the American Academy of Pediatrics for his achievements in the field of child development. In his work with President Lyndon Johnson's Office of Economic Opportunity, Dr. Richmond had established Head Start in 1965. In his acceptance speech, he challenged pediatricians to recognize child development as a basic science of pediatrics. He noted that the pediatricians' background in biology, including responsibility for enhancing the development of the nervous system, along with their ongoing relationships with children and families from infancy

J.C. Duby (✉)
Department of Pediatrics, Wright State University Boonshoft School of Medicine, Dayton Children's Hospital, Dayton, OH, USA
e-mail: DubyJ@childrensdayton.org

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through adolescence in the healthcare setting, uniquely positions the specialty to observe, understand, and nurture children's psychological and social development (Richmond 1967). This challenge was renewed in 1975 when Haggerty and colleagues coined the term "new morbidity" to refer to the complex psychological and social factors that affected children's health, development, and behavior, and urged pediatricians to develop strategies to partner with their communities to address these growing concerns (Haggerty et al. 1975). Reflecting on Richmond's remarks, Shonkoff and Green emphasized the need for a sophisticated understanding of human behavior and development is needed urgently to ensure effective prevention, early detection, and successful management of threats to child health (Shonkoff and Green 1998). Furthermore, they underscore that pediatrics must embody an integrative biopsychosocial model that links the mind and the body.

Challenges to pediatricians have included a call to rethink well-child care. Edward Schor argued that the traditional model of well-child care was not meeting the needs of families. Families were not bringing their children for many of the recommended visits and expressed dissatisfaction with the content of the visits. Schor called for rethinking the schedule, the structure, and the content of well visits. He emphasized that most parents acknowledge that they need guidance on raising their children and that they expect their pediatrician to provide information on child development and parenting, as well as the physical aspects of their child's health (Schor 2004). However, parents reported dissatisfaction with the behavioral and developmental advice offered in the pediatric setting (Coker et al. 2009).

In a 2012 policy statement, the American Academy of Pediatrics reported that advances in our understanding of how early environmental influences and genetic predispositions affect lifelong physical and mental health can promote transformative approaches to delivering pediatric healthcare services. Because adverse childhood experiences set the stage for many of the chronic diseases of adulthood, the academy challenged pediatricians to not only focus on identifying developmental concerns, but also to focus on interventions and community investments that will prevent and reduce the impact of early childhood adversity and toxic stress. An ecobiodevelopmental framework has been proposed to expand on the earlier concept of the biopsychosocial model. The framework recognizes the interactions between family and social relationships, and external environmental influences (ecology), and biological and genetic factors that influence development, learning, behavior, and health across the lifespan (Shonkoff and Garner 2012).

Thus, as the framework for the ecobiodevelopmental model of care has evolved, pediatricians within the pediatric medical home have become better positioned to support children and their families to set the stage for lifelong well-being. The Bright Futures recommendations for preventive pediatric health care include 16 well visits from before birth to 5 years of age (American Academy of Pediatrics 2016). These visits provide one of the few opportunities that many families have for ongoing contact with a professional team with expertise in child development.

The concept of the pediatric medical home was first promoted in the 1960s as a single place where all of a child's medical records could be found. It has now

evolved into a partnership with families to provide primary health care that is accessible, family-centered, coordinated, comprehensive, continuous, compassionate, and culturally effective (Sia et al. 2004). However, just 54 % of American children, including 58 % of children from birth to 5 years of age, and 36 % of American children living in poverty have access to a medical home (National Survey of Children's Health 2011–2012). Therefore, there are continued opportunities to reach and support children and families in a pediatric medical home.

Coker and colleagues (Coker et al. 2013) have questioned whether there is a future for well-child care in pediatrics. They argue that well-child care in its current form has not been effective in preventing the drivers of the chronic diseases of adulthood. They highlight the lack of evidence that pediatric well-child care has been effective in identifying and mediating the psychosocial environmental risk factors associated with toxic stress that lead to debilitating adult disease (Shonkoff and Garner 2012). They propose new models that emphasize a one-stop shop approach to well-child care that would include a team of allied professionals, including early childhood development specialists and other allied professionals, or a community connections approach, in which the pediatrician becomes the coordinator of a well-organized, community-based system of care (Coker et al. 2013). The American Academy of Pediatrics also emphasizes the essential role of forming collaborative relationships to promote mental health resilience through reinforcing child and family strengths and counseling families in healthy lifestyles (Committee on Psychosocial Aspects of Child and Family Health and Task Force on Mental Health 2009).

What Do Families Want?

Radecki et al. (2009) asked families what they wanted from well-child care. Among their findings were a desire to have a greater focus on their children's development and behavior during the visits as well as enhanced information exchange about healthy growth and development. Parents suggested using previsit materials to prepare them for the visit, making seminars and workshops available, using technology to provide information, and improving awareness of community resources (Radecki et al. 2009). Coker et al. (2009) interviewed minority, low-income families and found very similar themes. Families want more information on behavior and development and are open to a team-based approach that would involve multiple allied professionals. They are open to home visits, group sessions, and the use of technology such as text messaging to get information (Coker et al. 2009). Tanner and colleagues found very similar priorities when they interviewed pediatric clinicians (Tanner et al. 2009). In addition, Coker et al. (2013) found evidence that group well-child care visits can be as effective as 1:1 visits.

The third edition of the *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (Hagan et al. 2008) emphasized that children's health must be viewed in its broadest context, with healthy communities supporting

healthy children. *Bright Futures* encouraged an approach to health supervision that includes attention to health promotion activities and psychosocial factors that contribute to health while also emphasizing a focus on the strengths of children and families. Promoting mental health is identified as one of the significant challenges to child health and, along with the additional theme of promoting child development, sets the stage for exploring creative models for supporting families in ensuring the optimal health of their children. When considering health supervision in the pediatric setting, *Bright Futures* emphasized that the medical home is part of a system of care. Attention to the family's priorities is essential. Availability of evidence-informed anticipatory guidance, practice-based interventions, and linkages with community services is critical.

Emerging Trends

The American Academy of Pediatrics Task Force on the Vision of Pediatrics 2020 identified eight megatrends that were likely to have a profound influence on the future of pediatrics (Starmer et al. 2010). The Task Force concluded that to remain competitive, pediatricians must be responsive to the needs of more informed and connected consumers of their services. Pediatricians must lead innovation in the use of health information technology to serve their patients and should partner with allied professionals in a team approach to care. These trends may be especially important when considering innovation in facing the unmet needs of families for guidance in parenting and childrearing.

Kirp (2011) has concluded that the first of five big ideas for transforming children's lives is the opportunity to teach parents to teach their children. He argued that making high-quality, evidence-based, population-level supports for parents of young children will set the stage for the child's successful transition to preschool and ultimately a happy, productive adulthood. Yet, the manner in which such population-level supports can be made available is not yet clear. Many strategies for supporting families in supporting their very young children have been developed and disseminated to varying degrees. Healthcare professionals are exploring opportunities for integrating these models into a comprehensive system of well-child care. Below are the examples of models for promoting healthy social and emotional development through supporting families to promote early childhood development. These include:

- Brief practice-based opportunities
- One-stop shop opportunities
- One-stop shop/community connections opportunities
- Community connections through home visiting
- Media opportunities

Each of these models will be considered in turn below. The discussion is not intended to be exhaustive, but will highlight models that have evidence to support them as well as some innovative approaches to sharing evidenced-based information.

Brief Practice-Based Opportunities

Guidance for pediatric professionals highlights the importance of brief, practice-based opportunities to support families. These opportunities include the provision of brief verbal suggestions, handouts, and related materials, promoting early literacy development, and screening and surveillance for a variety of factors that may have an impact on children's development and behavior (Hagan et al. 2008).

Resources to Offer Parents. Glascoe and colleagues found that parents appear to respond best to information that focuses on their specific area of concern. They note that office posters can be helpful for broadening parents' range of interests. Brief verbal suggestions are effective for simple issues, but written information should be added for addressing more complex issues (see Table 1). A variety of resources are available to provide anticipatory guidance and to respond to parents' concerns or questions about challenges with parenting that are brief in duration and discrete in nature.

Healthy Minds: Nurturing Your Child's Healthy Development is a series of handouts developed by ZERO TO THREE and the American Academy of Pediatrics. Each handout is based on findings from the report *From Neurons to Neighborhoods: The Science of Early Childhood Development* (National Research Council & Institute of Medicine 2000). The information is age-specific through the first 3 years of life and offers strategies for parents to nurture their child's healthy development, and is available in English and Spanish.

The American Academy of Pediatrics has also developed a series of posters and artwork called: *Mom! Dad! Ask the Doctor About My Emotional Development, Too!* to promote the importance of mental health as part of a health supervision visit. Additional information for families is available at the Academy's Healthy Children consumer Web site.

The Centers for Disease Control and Prevention Learn the Signs. Act Early initiative has adapted materials from the American Academy of Pediatrics (Shelov and Remer Altmann 2009; Hagan et al. 2008) to create a series of Milestones Checklists that can be given to the family before a visit and can help them identify priorities for the visit. The checklists are in English and Spanish and are available for children from birth to 5 years.

The Ohio Chapter of the American Academy of Pediatrics has developed a series of 4 handouts to be used at the first postnatal visit, and at the 9-, 18-, and 36-month visits that focus on specific milestones and skills for promotion of healthy social and emotional development. The Building "Piece" of Mind materials are based on

Table 1 Resources for families and professionals

Resources for families	
Healthy Minds: Nurturing Your Child's Healthy Development	www.zerotothree.org/child-development/brain-development/healthy-minds.html
Mom! Dad! Ask the Doctor About My Emotional Development, Too!	www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Flyers-and-Ads.aspx
American Academy of Pediatrics	www.healthychildren.org
Milestones Checklists	www.cdc.gov/ncbddd/actearly/milestones/index.html
Building "Piece" of Mind	www.ohioaap.org
Text4Baby	https://www.text4baby.org
Little Kids, Big Questions: A Parenting Podcast Series From ZERO TO THREE™	www.zerotothree.org/about-us/funded-projects/parenting-resources/podcast/
Resources for professionals	
Bright Futures	www.Brightfutures.aap.org
Reach Out and Read	www.reachoutandread.org
Promoting First Relationships in Pediatric Primary Care	www.ncast.org
Triple P-Positive Parenting Program	www.triplep-america.com
Healthy Steps for Young Children Program	http://healthysteps.org/
Bellevue Project for Early Language, Literacy, and Education Success	http://pediatrics.med.nyu.edu/developmental/research/the-belle-project
Incredible Years Parenting Series	www.incredibleyears.com
Parent Child Interaction Therapy	www.pcit.org
Maternal, Infant, and Early Childhood Home Visiting Program	http://mchb.hrsa.gov/programs/homevisiting/index.html

the science of early brain and child development (National Research Council & Institute of Medicine 2000).

The resources outlined here are readily available, in the public domain, and can quickly be integrated into the primary care setting. Using these types of resources can set the stage for developing a culture within the pediatric medical home that lets families know that concerns about their child's development and behavior are a top priority.

Assessing and Promoting Health Literacy. When considering options for materials such as those just described, it is essential to attend to the health literacy of the population being served. Too often, the materials provided as part of preventive primary care are written at literacy levels that are above that of the child's caregivers. Pediatric providers must be prepared to deliver guidance effectively for low literacy families. Low literacy families have been shown to have less access to pediatric primary care, more unmet health needs, and more trips to hospital emergency departments (Sanders et al. 2009).

The Newest Vital Sign is an example of a brief practice-based tool for assessing health literacy. The Newest Vital Sign uses an ice-cream nutrition label and 6 questions that can be asked at the time that other routine vital signs such as height, weight, and blood pressure are done. It takes 2–3 min to complete. Based on the responses to the 6 questions, a determination is made as to whether the caregiver has limited literacy, possible limited literacy, or adequate literacy. Based on the results, the healthcare team can adjust their communication and the content of materials as well as determine whether the caregiver wishes to be referred for literacy supports (Shealy and Threatt 2015)

Early Literacy Promotion. Reach Out and Read is an excellent example of an evidence-based brief practice-based intervention. During well-child visits from infancy through 5 years of age, medical providers give a developmentally appropriate book to the child and offer guidance on reading aloud to their child. The program's mission is to help children grow up with books and with a love of reading. Reach Out and Read began in Boston in 1989. In 2014, there were over 5000 programs distributing 6.5 million books annually. Parents participating in Reach out and Read report a more positive attitude toward books and reading and are more likely to list reading aloud as a favorite activity to do with their child. Several studies have demonstrated improved language skills in participating children (Klass et al. 2009). Recommendations for reading guidelines for young children have been incorporated into the American Academy of Pediatrics Bright Futures guidelines. The American Academy of Pediatrics recommends that pediatric providers promote early literacy development for children beginning in infancy and at least until the age of kindergarten entry (American Academy of Pediatrics 2014).

Surveillance and Screening. With child development as the basic science of pediatrics, pediatricians have a strong foundation that allows them to observe and assess child development in the course of even brief interactions of children and of parent–child interaction. As mentioned previously, pediatricians are often the only professionals with expertise in child development who have the opportunity to observe a child's growth and development over time. This process of developmental surveillance is a key process for early identification of variations in development and behavior that may require further evaluation and intervention. Dworkin has emphasized that "with developmental surveillance, the importance of eliciting parents' opinions and concerns, obtaining a developmental history, and performing skilled, longitudinal observations of children" is an essential part of well-child care performed with families in collaboration with a well-trained professional (Dworkin 1989). Voigt and Accardo have also highlighted the important role of the pediatrician in identifying children with developmental concerns because they have the child's entire medical, family, and developmental history and can interpret developmental information within the broad context of the whole child (Voigt and Accardo 2015).

Additional recommendations have emerged which emphasize the importance of combining the use of standardized screening tools with surveillance to augment the ability of the pediatric professional to identify children with developmental and

behavioral concerns earlier, facilitating more timely evaluation and referral for services in the community (American Academy of Pediatrics 2006; Weitzman and Wegner 2015). Specific guidance for identifying children with autism spectrum disorders and motor delays is also available (Plauché Johnson and Meyers 2007; Noritz and Murphy 2013). Furthermore, the pediatric community has recognized the importance of identifying caregivers who may benefit from mental health supports, and families who may be affected by social determinants of health. This focus on the ecology in which a child grows and develops is an exciting area of emerging interest in pediatric preventive care. This is based on the science that clearly associates poverty, food insecurity, domestic and community violence, neglect, and problems with housing, utilities, transportation, and education with health outcomes.

The American Academy of Pediatrics recommends screening for maternal perinatal and postpartum depression in the first six months of an infant's life. The Edinburgh Postnatal Depression Scale and a simple 2-question screen have been recommended by the US Preventive Services Task Force (Earls 2010). In 2015, the American Academy of Pediatrics concluded that pediatricians can also play a central role in screening and identifying children at risk for food insecurity and in connecting families with needed community resources. A simple 2-question screen for food insecurity has been suggested (American Academy of Pediatrics 2015).

Dubowitz, Garg, and Health Leads have all developed structured, brief approaches to identifying risk related to the social determinants of health. Dubowitz has developed the Safe Environment for Every Kid (SEEK) model, which includes training for pediatric professionals and a 15-question checklist for a range of social risk factors (Dubowitz 2014). Garg used questions from the Children's Health Watch survey to measure 6 basic needs: child care, food security, household heat, housing, parent education, and employment in a cluster randomized controlled trial in 8 urban primary care centers. Mothers who participated in the survey were more likely to receive referrals for community services and were more likely to have received those services than controls (Garg et al. 2015).

Thus far, a number of brief, practice-based opportunities have been described. These focus on sharing information with families to promote healthy development, while also identifying children and families at risk for developmental, behavioral, and social concerns. The modern pediatric medical home must also be prepared to provide supports and to address concerns either in the context of a one-stop shop or by having strong links to community services.

One-Stop Shop Opportunities

A number of innovative programs for enhanced support for families in the pediatric setting have developed. Several are highlighted here. These approaches focus on promoting the caregiver–child relationship and often encourage expanding the healthcare team to include other professionals in addition to the pediatrician. There

is evidence that modeling and role playing appear useful when addressing problematic child behavior (Glascoe et al. 1998).

Integrated Behavioral Health Services. An important emerging trend is for pediatricians to partner with mental health professionals, including counselors, clinical social workers, psychiatrists, and psychologists in the same clinical setting offering integrated, collaborative models of care. Pediatric primary care settings are highly accessible to most families and are less stigmatizing than mental health facilities. Mental health professionals in the primary care setting are well positioned to offer problem-focused behavioral interventions, including programs such as Triple P and the Incredible Years, which are discussed later. Integrated settings facilitate warm handoffs from the pediatrician to the mental health professional, increasing the likelihood of establishing ongoing care for behavioral or emotional concerns. A psychologist can also supervise a team of lesser trained professionals in the pediatric setting, assuring that all professionals are working at the top of their license (Stancin and Perrin 2014).

Health Leads. Health Leads is a model that enables providers to "prescribe" basic resources such as food and heat. Trained student advocates stationed in the clinics work with patients to "fill" those prescriptions by accessing community resources and public benefits. In 2014, nearly 900 Health Leads Advocates across seven cities nationwide assisted over 13,000 patients and their families (Health Leads 2015). An urban clinic in Maryland that offered 12 different on-site services, including Health Leads, found that caregivers who used 3 or more of the services showed greater satisfaction with the clinic and a stronger perception of the clinic as a medical home (Vasan and Solomon 2015).

Promoting First Relationships. Promoting First Relationships in Pediatric Primary Care is an approach that addresses the transition to the "new morbidity" first described by Haggerty et al. (1975). This program is rooted in child development and attachment theory, and operationalizes a core set of concepts from the infant mental health literature into pediatric primary care practice. Pediatric professionals learn skills to help caregivers of young children build their sense of confidence and competence, helping them to better understand the emotional needs and feelings of their child, and strengthening the parent–child relationship. The program emphasizes fundamental concepts of building healthy relationships, setting the stage for prevention of adverse childhood experiences and toxic stress. Strategies include: reinforcing the importance of reciprocal interaction and mutual delight between parent and child; promoting reflection skills; encouraging emotional regulation skills; and learning skills for repairing relationships (Kelly et al. 2013).

A randomized controlled trial of Promoting First Relationships demonstrated reduced infant separation distress with improvement in sleep patterns in toddlers reunited with their birth parent after spending time in foster care (Oxford et al. 2013). Another randomized trial showed improved caregiver sensitivity and better understanding of toddlers who were in foster care (Spieker et al. 2012). A third study using Promoting First Relationships as a home visiting program found that more foster/kin caregivers who received the intervention provided stable,

uninterrupted care and eventually adopted or became the legal guardians of the toddlers in their care after two years, compared to foster/kin caregivers randomized to the comparison condition (Spieker et al. 2014).

Healthy Steps for Young Children Program. The Healthy Steps for Young Children Program was developed at Boston University in 1994 (Zuckerman et al. 1997, 2004); Healthy Steps adds a child development specialist—typically a nurse, early childhood educator, or social worker—to the health supervision team. Additional services include more time to spend discussing preventive issues during well-child visits, home visits, a telephone information line exclusively addressing developmental and behavioral concerns, written materials, and more seamless linkages to community resources and parent support groups. Enhanced well-child visits are conducted by a pediatric clinician and the child development specialist, either jointly or consecutively. Visits are designed to administer physical examinations, answer parental questions, and to take advantage of "teachable moments" to help parents better understand their child. Risk factors such as maternal depression, substance use, and maternal stress are assessed. Minkovitz et al. (2003) interviewed 3737 families who participated in the Healthy Steps evaluation process at 15 sites and concluded that the program enhanced quality of care and improved selected parenting practices (Piotrowski et al. 2009) completed a systematic review of 13 studies that have evaluated Healthy Steps. They found that the Healthy Steps program is effective in preventing negative child and parent outcomes and enhancing positive outcomes, and they recommended that the Healthy Steps program be more widely disseminated to relevant stakeholders.

Video Interaction Project and Building Blocks. The Bellevue Project for Early Language, Literacy, and Education Success includes the Video Interaction Project and Building Blocks. The project was developed in the Department of Pediatrics at New York University School of Medicine and Bellevue Hospital Center to support primary care interventions that would lead to improved child outcomes by addressing parenting and parent–child interaction. In the Video Interaction Project, a child development specialist covers a curriculum focused on promoting supportive parent–child interaction and then facilitates interactions in play and shared reading by reviewing a video of the parent and child interacting. This offers an opportunity to discuss developmental, behavioral, and emotional issues. Fifteen 30–45 min sessions are offered through the first 3 years of life (Mendelson, Cates, Weisleder, Berkule, and Dreyer). In the Building Blocks Project, families are mailed written pamphlets and learning materials monthly from birth until a child is 3 years old. The materials include a curriculum that encourages verbal interaction in pretend play, shared reading, and daily routines.

Mendelsohn et al. (2005) performed a randomized controlled trial with poor Latino children whose mothers had not completed high school and found that there were significant benefits in cognitive and language development for the children whose mothers had completed 7th–11th grade, but not for those who completed 6th grade or less. Other findings have included less media exposure, enhanced provision of toys, more shared reading, more teaching, and more parental verbal responsivity at 6 months old for the Video Interaction Project group. The less

intense Building Blocks intervention showed enhanced provision of toys and shared reading when compared to controls (Mendelsohn et al. 2011a, b). When children were 33 months old, parents who participated in the Video Interactive Project were less stressed and their children were more likely to have normal cognitive development and less likely to have any delayed development (Mendelsohn et al. 2007).

Primary Care Triple P. Triple P-Positive Parenting Program is a multilevel system of behavioral family intervention that is based in social learning theory (Sanders 1999). The model includes five levels of intervention that increase in intensity depending on the individual needs of the family. Level 3, or Primary Care Triple P, is a brief 1- to 4-visit intervention, of 20 min each, designed to address parents' concerns about discrete behavior challenges that do not rise to the level of a clinical diagnosis. Level 3, or Primary Care Triple P providers, promotes self-regulation within the parents so that they can better understand the cause of their child's behavior challenge, learn to track the behavior using simple tools, and learn strategies to encourage more desirable behavior and manage misbehavior effectively. Modeling and role play are used to teach parents effective strategies. An extensive series of tip sheets, videos, and provider resources are available to trained and accredited practitioners.

Turner and Sanders (2006) evaluated Primary Care Triple P as a preventive strategy in a randomized controlled trial with parents of preschoolers with mild to moderate discrete behavior challenges. Services were delivered by child health nurses in a primary care setting in Australia. Children in the intervention group showed improvement in the targeted behavior, and parents showed reduced reliance on dysfunctional parenting practices. Primary Care Triple P may be a valuable component of a comprehensive medical home that will promote healthy parent–child interaction, and has the potential to reduce the risk for toxic stress and adverse outcomes in adulthood.

Widespread dissemination of these promising practices hinges on changes in payment for healthcare services that recognize the contribution of child development specialists, mental health professionals, and other allied professionals to positive parenting and child developmental outcomes.

One-Stop Shop/Community Connections Opportunities. Parents have reported an interest in getting information in groups, workshops, or seminars. In pediatric medical homes that include integrated behavioral health services, expanded behavioral family intervention can be offered in the one-stop shop. In other pediatric settings, pediatricians are urged to form strong connections with resources in their communities, promoting opportunities for successful referrals for evidence-based supports. Several evidence-based interventions are highlighted here.

Triple P. Level 2 Triple P offers a selected seminar series which includes an introduction to the strategies of positive parenting. Parents may attend up to three 90-minute seminars on the Power of Positive Parenting; Raising Confident, Competent Children; and Raising Resilient Children. Tip sheets are given to participants. These seminars can be hosted in the pediatric medical home or anywhere in the community where families tend to gather and are delivered by a child development specialist, nurse, social worker, or counselor. Sanders et al. (2009)

evaluated the seminar series with 109 Australian families with 4- to 7-year-old children. They found a significant reduction in parental reports of child behavior problems and dysfunctional parenting styles with the introductory seminar alone. Participation in all three seminars was associated with significant improvements in all dysfunctional parenting styles and in the level of inter-parental conflict. This suggests that an intervention that requires minimal time commitment from the parents may have a positive impact on parent–child interaction.

For parents who want or need more intensive supports or intervention, Level 4 Triple P is a broad-based curriculum for families whose children have multiple behavior challenges that significantly affect functioning across settings. Level 4 Triple P can be administered in small groups for 5 sessions or with individual families for 8–10 sessions and covers a wide range of strategies for promoting desirable behavior and managing misbehavior. Families have a workbook and homework exercises, review video examples, and are encouraged to practice new skills during sessions. The practitioner provides opportunities for modeling, role play, and constructive feedback. These activities provide substantial opportunities to foster parental self-regulation, leading to sustained benefits from the intervention (Sanders and Mazzucchelli 2013). Bodenmann et al. (2008) completed a randomized controlled trial of Level 4 Group Triple P with 150 couples in Switzerland and found lower rates of child behavior problems and improvement in maternal levels of stress, parenting self-esteem, and parenting practices compared to controls and couples who received a marital distress intervention.

Level 5 Enhanced Triple P is for parents whose family situation is complicated by problems such as partner conflict, stress, or mental health issues. Four modules address partner relationships and communication, stress management, coping skills, and anger management. These modules are completed in conjunction with Level 4 services.

Incredible Years. The Incredible Years Parenting Series is delivered in 12–14 weekly group sessions that meet for 2.5 hours (Webster-Stratton et al. 2008). The series is designed for parents of 2- to 10-year-olds and the behavior management content is similar to Triple P. Videotaped examples of child behavior are used to facilitate discussion. Role play gives parents an opportunity to practice new skills and participants are encouraged to establish a social support network with other parents. The program has been shown to be effective in reducing conduct problems in children with oppositional defiant disorder/conduct disorder and as a prevention program for families of children in Head Start, kindergarten, and first grade (Bauer and Webster-Stratton 2006).

Both Level 4 and Level 5 Triple P and the Incredible Years Parenting Series can be offered by a mental health professional, nurse, or educator as part of a one-stop shop, integrated pediatric medical home, or in a community setting with strong connections to the medical home.

Parent–Child Interaction Therapy. Parent–Child Interaction Therapy was developed in the 1970s by Sheila Eyberg and colleagues. Therapy involves 2 phases of intense direct coaching which usually requires about 15 sessions. The first phase, Child-Directed Interaction, is focused on improving the parent–child relationship and attending to positive child behavior. The second phase,

Parent-Directed Interaction, focuses on giving good instructions and using consistent consequences. More than 150 studies have demonstrated its efficacy, with maintenance gains up to 6 years (Funderburk and Eyberg 2011). The therapists complete certification training and must be a licensed mental health provider with at least a master's degree.

Community Connections Through Home Visiting

Tschudy et al. (2013) have argued that merging the family-centered pediatric medical home with evidence-based home visiting would promote efficiency and effectiveness, improve quality of care, reduce duplication, reinforce priorities, reduce costs, and reduce health disparities. They note the synergistic goals between them and see this type of merger as a natural progression toward a medical neighborhood, linking the medical home with community and social service agencies (Tschudy et al. 2013). The Healthy Steps program described earlier includes home visits as an important component contributing to its positive outcomes. The Building Healthy Children collaborative combined the Parents as Teachers home visiting program discussed below with therapy for parent–child trauma and maternal depression, along with care in the medical home for children ranging from newborns to 2 years of age. Participating families included some whose children had been exposed to domestic violence and some mothers who had been victims of abuse or neglect or suffered from depression. At the age of 3, participating children had lower rates involvement with child protective services, lower rates of foster care placements, and higher rates of preventive care (Paradis et al. 2013).

Innovative approaches like these may have particular benefit for at risk families. The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) was authorized by the Affordable Care Act in 2010 and is administered by Health Resources and Services Administration. Funding provides grants to promote:

- Improved maternal and newborn health;
- Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits;
- Improvement in school readiness and achievement;
- Reduction in crime or domestic violence;
- Improvements in family economic self-sufficiency; and
- Improvements in the coordination and referrals for other community resources and supports.

MIECHV requires that at least 75 % of grant funds be spent on programs to implement evidence-based home visiting models. The US Department of Health and Human Services has identified 19 home visiting models with demonstrated effectiveness (Avellar et al. 2015).

Several of those models will be briefly described here.

It is important that early childhood providers be aware of the programs that are available in their communities and ensure that the connections with these resources are in place for their families that qualify.

Models that have been disseminated broadly over many years include Early Head Start-Home Visiting, Healthy Families America, Nurse Family Partnership, and Parents as Teachers.

Early Head Start-Home Visiting. Early Head Start-Home Visiting serves low-income pregnant women and families with children less than 3 years. The program aims to promote healthy prenatal outcomes, enhance the development of young children, and promote healthy family functioning. Services include weekly, 90-minute home visits, and twice-monthly social activities. Brooks-Gunn et al. (2013) reported that at the ages of 2 and 3, children involved in Early Head Start show enhanced cognitive and language skills, reduced aggressive behaviors, higher engagement with the parent during play, and higher rates of immunizations. At the age of 5, children have significantly reduced behavior problems and enhanced positive social skills and approaches to learning.

Healthy Families America. Healthy Families America (HFA) is a program of Prevent Child Abuse America designed to support parents facing single parenthood, low income, a childhood history of abuse and adverse child experiences, or current or previous issues related to substance abuse, mental health issues, and/or domestic violence. Families must enroll during pregnancy or at the time of birth. HFA aims include: (a) reducing child maltreatment, (b) increasing utilization of prenatal care, (c) and improving parent–child interactions and school readiness. HFA sites offer at least one 60-minute home visit per week for the first 6 months after the child's birth. After the first 6 months, visits might be less frequent and may continue until the child is 3–5 years of age. Dumont et al. (2008) completed a randomized trial of 1173 families at risk for child abuse and neglect in New York. They found that rates of serious abuse among families at the highest risk for potential abuse were 75 % lower in the HFA group compared to controls. This study emphasized the potential value of targeting services to those at highest risk.

Nurse Family Partnership. Nurse Family Partnership (NFP) uses nurses to provide the most intensive intervention for the highest risk population. Home visits lasting 60–75 min are offered to poor, first-time mothers beginning in pregnancy and extending through the child's first 2 years. NFP is designed to (a) improve prenatal health and outcomes, (b) improve child health and development, and (c) improve families' economic self-sufficiency and/or maternal life course development. Ideally, the first visit is early in the second trimester and must be no later than 28 weeks of gestation. The frequency of visits ranges from weekly to monthly.

Olds (2008) has summarized 30 years of research with NFP, including three randomized prospective trials with up to 15-year follow-up. He noted that the greatest benefits of the program came for the highest-risk families, namely those with low-income, unmarried mothers, and particularly teen mothers. Benefits were

seen in pregnancy outcomes, the child's development, and in the parental life course. His research also indicated that having a nurse deliver the services makes a difference over a paraprofessional. Olds argued that it will not be cost-effective to make such programs universally available to all pregnant women, and that the benefits for low-risk families would not be significant enough to justify the cost.

Parents as Teachers. Parents as Teachers (PAT) gives flexibility to local programs to determine the population and length of time that they serve families from pregnancy up to kindergarten entry. PAT aims to (a) increase parent knowledge of early childhood development and improve parenting practices, (b) provide early detection of developmental delays and health issues, (c) prevent child abuse and neglect, and (d) increase children's school readiness and school success. There are 4 components: at least 10–12, 50–60 min home visits annually; monthly group meetings; health and developmental screenings for children; and a resource network for families. Zigler et al. (2008) studied 5721 children in Missouri and found that those whose families had participated in PAT had better school readiness, which correlated with the length of participation in PAT, and was related to better parenting practices, more reading to children at home, and a greater likelihood of enrollment in preschool. School readiness predicted academic achievement in the third grade, supporting the notion that intervention prior to school entry is vital for positive academic outcomes in at risk children.

Home visiting programs, particularly for at risk families, can be a natural partner with the pediatric medical home to improve community connections, improve access to services, and improve adherence with preventive care.

Media Opportunities

Today's parents of young children are constantly turning to the Internet and to social media to obtain information and stay connected. According to the Pew Research Center 2015 survey, 86 % of 18- to 29-year-olds and 83 % of 30- to 49-year-olds owned a smartphone. Nearly 100 % of those in these age groups use text messaging and over 90 % use the Internet with their smartphones. Mobile phone ownership by American adults increased from 65 % in 2004 to 92 % in 2015, with 84 % using the Internet (Anderson 2015; Pew Research Center 2015a). Pediatric providers are well positioned to guide families toward reliable information that reflects best practice.

Text4Baby is a mobile information service designed to promote maternal and child health through text messaging. Pregnant women and new mothers who enroll receive three free text messages per week that are timed to their delivery date and continue through their child's first birthday. Text4Baby has reached more than 500,000 mothers since 2010 and is supported by a public–private partnership of health departments, academic institutions, health plans, businesses, and the federal government. Preliminary evaluation findings indicate that Text4Baby is increasing users' health knowledge, facilitating interaction with their health providers,

improving their adherence to appointments and immunizations, and improving their access to health services (Remick and Kendrick 2013). A randomized controlled trial of Text4Baby at Madigan Army Medical Center demonstrated that high levels of exposure to the messages resulted in lower levels of self-reported alcohol consumption (Evans et al. 2015). However, others have questioned the national dissemination of a program without clear evidence to support its benefits with well-designed evaluations (Van Velthoven et al. 2012).

Text messages are one avenue to reach parents. Online parenting interventions are also receiving increased attention. As an example, Sanders et al. (2012) completed a randomized controlled trial of an intensive 8-module version of Triple P Online and found high levels of parental satisfaction with the program, reduced child behavior problems, and improved parenting practices post-intervention.

Podcasts represent an additional avenue to reach parents of young children. From 2008 to 2015, the number of Americans who have listened to a podcast rose from 18 to 33 % (Pew Research Center 2015b). Little Kids, Big Questions: A Parenting Podcast Series From ZERO TO THREE™ is a series of 12 free podcasts that can be downloaded. The topics were chosen based on input from a survey of parents. Expert interviews focus on how to apply the research of early childhood development to daily interactions with young children.

New media opportunities are becoming available every day. Mobile applications are increasingly desirable, particularly with the ubiquitous nature of smartphones. It is essential that pediatric professionals are attuned to new developments in media, critically evaluate them, and be prepared to offer sound advice to families on new technologies for education, information, and behavior change.

Conclusion

The pediatric community has been challenged to rethink the traditional models for well-child care. Evidence indicates that an emphasis on health promotion—especially social, emotional, and developmental health—is critical to addressing the major drivers of adverse adult disease, including mental illness. The foundation for healthy social and emotional development is rooted in the quality of the parent–child relationship. There are many opportunities for the pediatric medical home to support parents in teaching their children, setting the stage for them to be healthy, productive adults. Opportunities range from brief, practice-based interventions, to expanding the scope of well-child care to include a one-stop shop model with numerous allied professionals, including child development specialists, social workers, and mental health providers. Establishing community connections and coordinating those connections for families are other opportunities for the pediatric medical home. It is vital that pediatric providers be well connected to parenting services and home visiting programs in the communities and continually evaluate the ever-expanding resources available in the media.

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Neighborhood Approaches to Supporting Families of Young Children

Joyce Elizabeth Dean, James T. Seymour and Steven Rider

Introduction

With the ever-growing technology and family mobility, life in America has changed. In some neighborhoods across the country, neighbors may no longer know and care about each other as neighbors once did. However, neighbor connections can be powerful resources for families with young children, creating neighborhoods that are rich in resources that support and strengthen families. Given the potential that place-based approaches offer, this chapter briefly reviews three programs that use a neighborhood-based approach to strengthen families in poverty. The **Harlem Children's Zone** (HCZ) is a non-profit organization that seeks to disrupt the cycle of generational poverty by providing free support in the form of parenting workshops, pre-school programs, charter schools, and child-oriented health programs for thousands of children and families within a well-defined area in Harlem, New York. The goal of HCZ is to support children to succeed in school, through college, and into the job market. Based on the success of HCZ, the Obama administration developed the **Promise Neighborhoods** program, which has provided funding for other impoverished US communities to adapt HCZ approaches to their local needs. A third innovative program, the **Fostering Hope Initiative** (FHI), is also described. FHI is a collective impact initiative operating in three counties in northwest Oregon

J.E. Dean (✉)
Dean/Ross Associates, Eugene, OR, USA
e-mail: joyce2890@comcast.net

J.T. Seymour
Catholic Community Services of the Mid-Willamette Valley and Central Coast, Salem, OR, USA
e-mail: jseymour@ccswv.org

S. Rider
Pacific Research and Evaluation, Portland, OR, USA
e-mail: steve@pacific-research.org

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that has demonstrated promise in a recent quasi-experimental study. The initiative concentrates on both professional and voluntary supports for vulnerable families in targeted high-poverty neighborhoods. Currently focused on early childhood, the dream for FHI is to build a prenatal-to-career system of supports so that all children grow into healthy, successful adults.

> Children do well when their families do well, and the families do better when they live in supportive neighborhoods (Annie E. Casey Foundation, 2000, p. 2).

Rationale for Neighborhood-Based Approaches

Families in high-poverty neighborhoods face multiple risks for poor child outcomes related to helping their children succeed in school, in the community, and in their adult lives. These neighborhoods have higher rates of child maltreatment, poorer health, lower academic achievement scores, and few assets for supporting families to thrive. Living in such circumstances imposes heavy developmental burdens during early childhood and can result in substantial individual and societal costs in the future (Shonkoff and Phillips 2000, p. 7). Fleming (2013), in testimony prepared for the Robert Wood Johnson Foundation Commission to Build a Healthier America, gave striking examples of how neighborhoods and census tracts can have vastly different health outcomes than others nearby, even when the average for the community as a whole may be relatively good. He argued that access to health care is not the answer. Instead, to improve these wide health disparities, "we need to look outside the walls of the clinic and focus on fixing the characteristics of local communities that underpin good health" (p. 3). As a result, he argues for deliberately investing community resources in neighborhoods most in need.

Franklin and Edwards (2012) assert that the absolute level of poverty in a neighborhood is less important than the distribution of poverty. They state that problems "arise not from poor individuals and families, but from their geographic concentration" (p. 172). The solution they and others offer is to replace high-concentration affordable housing developments with mixed-income housing, to change the mixture of poverty in the neighborhood.

Korbin et al. (2000) summarized sociological and political research that seeks to differentiate between communities and neighborhoods and identifies benefits to neighborhood-based programming. From a sociological perspective, they describe neighborhoods as having "social networks" and, from a political perspective, emphasize that neighborhoods are able to recognize common issues and act on them as a unit. According to the authors, it is these qualities, specific to neighborhoods and often differing from the larger communities where they are nested, that can facilitate improved outcomes in the social service sector. Korbin and colleagues argue that neighborhood-based efforts are more likely to increase social capital, bringing neighborhood members together to support each other and collectively influence neighborhood well-being.

Social capital is a valuable commodity in neighborhoods. Community organizers entered neighborhoods seeking a common issue and then applying techniques recommended by Alinsky (1971) and others to develop local leaders to bring residents together to improve their neighborhoods by organizing against a common, outside enemy. Since then, other approaches, such as asset-based community development (McKnight and Block 2010; also see http://www.abcdinstitute.org), have sought to bring people together around common interests—rather than common threats—to grow the fabric of a connected neighborhood. These connections in a neighborhood provide social capital and with it the power to improve the lives of individual residents and the neighborhood as a whole.

Similarly, Carrasco (2008) encourages investment in developing community engagement, changing community environments to promote a sense of community responsibility for children, families, and neighbors. Using a public health approach, this would mean looking at the issue as one of greater child well-being rather than only as an intervention that takes place one person at a time.

Development of Place-Based Approaches

Because of the strong influence that neighborhoods and local communities can have on families, "place-based" approaches have become a trend in programs and government funding. For example, Choice Neighborhoods is a program of the US Department of Housing and Urban Development (HUD) that supports locally driven strategies to address struggling neighborhoods with distressed public or HUD-assisted housing through a comprehensive approach to neighborhood transformation. With a foundation based in improving the infrastructure of a neighborhood, Choice Neighborhoods also seeks to improve educational outcomes and intergenerational mobility for youth with services and supports delivered directly to youth and their families ("Choice Neighborhoods," http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/ph/cn). Three other place-based initiatives, examined below, include the Harlem Children's Zone, Promise Neighborhoods, and the Fostering Hope Initiative.

Harlem Children's Zone

The highly successful Harlem Children's Zone (HCZ.org) was established by Geoffrey Canada, then Executive Director of the Rheedlen Centers for Children and Families. In 1999, Canada realized that the various programs for children and youth that they operated in upper Manhattan, while helpful, did not create lasting change for the children they served, nor were they able to serve all of the children who needed support. Based on the theory that "each child would do better if all the children around him were doing better" (Tough 2008, pp. 4–5), Canada chose a

one-block pilot, then expanded to target a 24-block area of central Harlem, and built a "pipeline" of programs designed to address the way parents raise their children, the way schools teach them, and the neighborhood in which they live. His quest became building a system that would help children move out of poverty. Harlem Children's Zone includes a comprehensive array of programs in education, family and community, and health, now encompassing 97 blocks of Harlem and 70 % of children in the Zone engaging in the HCZ pipeline of programs each year ("The beginning of the Children's Zone," http://hcz.org/about-us/history/).

HCZ promises to support all children within the Zone to be successful not only in school, but to go on to college and/or career. Using multiple programs, HCZ supports optimal child development from "cradle to career," beginning with a "Baby Academy," continuing through their own Promise Academy Charter Schools and supports provided to children in public schools, and on to help youth from the Zone prepare for and succeed in college and career. The development of Harlem Children's Zone is well-documented in the book *Whatever It Takes* (Tough 2008).

HCZ Education programs include the following:

- Programs for expectant parents (e.g., The Baby College®) and caregivers for infants through toddlers, which deliver a strong understanding of brain and child development along with the skills to raise happy, healthy children.
- Pre-K and Promise Academy® K-12 Charter Schools, which ensure children enter kindergarten ready, and that promise that every student will get to and through college.
- Programs to support students attending public schools, including tutoring, after-school programs, cultural activities, and social–emotional support and guidance.
- College preparatory programs offer tutoring, standardized test prep, assistance with applications, and activities to expose the students to potential career paths.
- A College Success Office that does "whatever it takes" to help youth successfully complete college, enter the workforce, and become productive, self-sustaining adults.

Underlying the educational programs, HCZ also offers Family and Community Programs to support success, including Community Centers with after-school, night, and weekend programming; door-to-door outreach encouraging families to participate in HCZ programs; and free legal services, financial counseling, and tax preparation programs. HCZ also provides foster care prevention programs with the goal of getting HCZ families the services they need to become more stable and to prevent foster care placement. HCZ directly addresses health outcomes with nutrition education and activities to engage children and families throughout the Zone in developing lifelong healthy habits.

The breadth and depth of the Harlem Children's Zone are impressive. So are their results:

- 70 % of the children who live in the Zone are engaged in one or more HCZ programs, achieving a "tipping point" in the Zone, which is changing the culture of what is expected for children and youth.
- More than 4000 parents have graduated from The Baby College parenting workshops.
- 100 % of HCZ's pre-kindergarteners were assessed as "school ready."
- 92 % of students who have applied to college have been accepted.
- $20,000,000 in scholarships and grants were awarded to the most recent set of college freshmen.
- 881 students are attending college.
- $5,400,000 in tax refunds were gained by 3350 local families with the help of the Tax Preparation Program.

It is no wonder that the Harlem Children's Zone became the template for the federal Promise Neighborhoods program, or that, since 2005, HCZ's Practitioners Institute has hosted workshops for 445 US communities and 139 international delegations ("Harlem Children's Zone," http://hcz.org/wp-content/uploads/2014/04/FY-2013-FactSheet.pdf, 2013; "*Our Results*," http://hcz.org/results/).

Promise Neighborhoods

Promise Neighborhoods, funded through the US Department of Education (USDOE), is another place-based initiative, designed to replicate HCZ's cradle-to-career approach in other distressed neighborhoods across the country. The program's vision is that all children and youth growing up in Promise Neighborhoods have access to great schools and strong systems of family and community support that will prepare them to attain an excellent education and successfully transition to college and a career. Focusing on the most distressed communities, Promise Neighborhoods build a complete continuum of coordinated cradle-to-career solutions of both educational programs and family and community supports, with great schools at the center. USDOE awarded its first Promise Neighborhood grants in 2010 (for additional information on Promise Neighborhoods, go to: http://promiseneighborhoods.org/ and http://www2.ed.gov/programs/promiseneighborhoods/index.html).

> Our job across America is to create communities of choice, not of destiny, and create conditions for neighborhoods where the odds are not stacked against the people who live there.
>
> **Barack Obama**
> *on the Promise Neighborhoods Initiative*

The Fostering Hope Initiative

The Fostering Hope Initiative (FHI) is a place-based initiative focused on strengthening poor and vulnerable families in selected high-poverty neighborhoods in three counties—Marion, Polk, and Yamhill—in northwest Oregon. FHI is based upon the belief that neighborhoods, public agencies, non-profit faith-based and secular organizations, schools, parents, and children can work together to create a system of neighborhood support and services that will strengthen families and ensure children will become successful, productive adults.

Collaborators designed the Fostering Hope Initiative to take advantage of research on neighborhood influences, brain development, and the effects of "toxic stress" on parents and their children. Thus, FHI focuses on specific neighborhoods; employs Neighbor Connectors to mobilize neighborhood residents in supporting families and child well-being; uses non-threatening, non-stigmatizing methods to attract the families with the highest risk of negative outcomes to participate; provides ongoing parent education and support groups available to all parents in the focus neighborhoods; and, through its collaborators, provides professional home visitors for high-risk families to deliver in-home parenting education, information on child development, and access to other professional services and supports.

FHI, Collective Impact, and the Collaborative Partnership

FHI meets the five conditions of success for a collective impact initiative as defined by Kania and Kramer (2011): a common agenda, shared measurement system, mutually reinforcing activities, continuous communication, and a backbone organization that provides the infrastructure to support the initiative. Since its start, FHI has been led by Catholic Community Services of the Mid-Willamette Valley and Central Coast (CCS). As a backbone, CCS provides a program director, applies for funding to support FHI's work, coordinates and facilitates meetings, compiles and reports data, and supports services provided by the voluntary sector within FHI neighborhoods. FHI partners are dedicated to the common vision, "Every child and every youth in every neighborhood lives in a safe, stable, nurturing home, is healthy, succeeds in school, and goes on to financial self-sufficiency."

Research analyzing the benefits and challenges of collaborative service delivery has been voluminous. As a result, interagency collaboration, when meeting certain criteria, is generally presumed to improve the quality of service delivery in programs that serve young children (Gardner and Young, 2009). By coordinating services rather than operating in isolation, providers can offer comprehensive programming that is better able to meet the needs of their clients. The original Marion County members of the collaborative partnership underlying FHI spent over

a year in collective planning, identifying the FHI vision, values, and planned services.

FHI began when, in 2008, CCS and others participated in a Casey Family Programs conference, where Casey shared their 2020 vision: "Safely reduce foster care by 50 % by 2020." The Oregon delegation included staff from the Department of Human Services-Child Welfare, a judge, a state legislator, service providers, and others. After returning from the conference, these representatives began meeting together to discuss the question: "How can we build a neighborhood-based system of family support strong enough to reduce the need for foster care by 50 % by 2020?" Oregon's Governor Ted Kulongoski and Paul De Muniz, Chief Justice of the Oregon Supreme Court, issued a joint statement declaring the safe and equitable reduction in the number of Oregon children in foster care as one of the State's highest priorities. When Oregon was subsequently selected as a Casey Family Programs project state, CCS and its partners in FHI had already begun work around planning a neighborhood-based initiative to strengthen families, promote optimum child development, and reduce child maltreatment and foster care. As the initial vision of safely reducing the need for foster care grew, CCS invited the additional organizations to the table that had a stake not only in preventing child maltreatment and reducing foster care, but also in improving children's education and health outcomes.

Now, FHI partners include representatives from education, early learning, the business community, Latino organizations, faith-based groups, the public and private sector social service network, and health care administrators and practitioners. FHI recruits new partners based on the needs of specific neighborhoods or projects. The nature and intensity of partnerships vary—from those organizations and individuals that serve in a leadership role to those who provide resources for an individual neighborhood event. FHI partners range from a pediatric clinic whose physicians donate funds to purchase a bag of groceries for participants in a class on how to select and cook nutritious food—so the moms can practice what they have learned, to a church that provides space twice each month for a free dinner that brings neighborhood residents together; from a sorority of retired librarians that set up and maintain a library at La Casita, a small house loaned to FHI by another church, to the next-door Head Start program which loans the use of its playground for La Casita events; from high-school students who built Little Free Libraries as a class project to promote reading to the City of Salem's Department of Community Development's Neighborhood Partnerships program that has worked with residents to address neighborhood priorities; from early-learning providers' home-visiting services to local banks that present classes on financial literacy; and from the churches that sponsor Safe Families for Children[1] respite care to their members who

[1]Safe Families for Children (SFFC) is a national faith-based movement to provide vulnerable parents with mentoring relationships and tangible support in times of need. SFFC believes children will be safe and well-cared for if vulnerable families have a network of support, including both crisis and planned respite for their children. Carefully vetted and trained volunteer families, prompted solely by compassion, build relationships with these families and open their homes to their children. This allows parents to have the time and space to rest and work out their problems

volunteer their time and resources for families in crisis. These are all partners in Fostering Hope. These relationships expand outreach into the community, enrich leadership, and strengthen FHI's capacity to provide services for families and to address neighborhood needs.

While a handful of organizations manage FHI's strengthening families work in each county, it is this variety of partners at all levels of contribution that bring the depth and richness to the initiative. Together, partners provide an array of services, resources, and supports to strengthen families and create better neighborhoods—building the infrastructure to improve and scale up the programs proven to have high-impact results for at-risk children, youth, and adults.

FHI Key Assumptions

FHI's desired outcomes and strategies are based on nine key assumptions that are grounded in credible science. These are as follows:

1. Safe, stable, and nurturing relationships are the key social determinant of optimum child development.
2. Toxic stress disrupts safe, stable, and nurturing relationships by interfering with the brain's executive function (working memory, inhibitory control, and mental flexibility) and triggering fight–flight responses (National Scientific Council on the Developing Child 2005/2014. Retrieved from www.developingchild.harvard.edu).
3. Acute and/or chronic adversity in childhood leads to hyper-sensitivity to stress. Trauma-informed approaches to service delivery are, therefore, often necessary.
4. Toxic stress can be reduced and access to executive function developed by providing support and services, which address the sources of stress; by teaching knowledge, skills, and personal attributes to help parents become more resilient in the face of stress; and by promoting Strengthening Families Protective Factors™ at home and in the neighborhood.
5. Early childhood investment will benefit both a child's capacity to learn and the child's prospects for lifelong health.
6. Living in a safe neighborhood where neighbors know and care about one another strengthens families and promotes and protects the optimum child development.
7. The intentional pursuit of quality and accountability—that is, grounding service design in credible science, evaluating service delivery to ensure fidelity to

(Footnote 1 continued)

without worry about losing parental custody. SFFC started with the Lydia Home Association in Illinois, which is affiliated with the Evangelical Free Church of America. In Marion and Polk Counties, 14 faith communities have signed on since CCS brought SFFC to Oregon in 2010. CCS is expanding the SFFC movement in Polk and Yamhill Counties and currently recruiting parishes and families across all three counties. For more information on SFFC, see: www.safe-families.org.

service design, evaluating results, and using the data to continually improve decision making—is vital to achieving the desired results.
8. Collaboration is crucial for solving complex social problems and creating collective impact.
9. Public policy can strengthen families and promote/protect optimum child/youth development, or it can undermine families and child/youth development.

To date, FHI has primarily focused on early childhood. Therefore, FHI's overall desired outcome is optimum child development—children are safe and healthy and prepared to succeed in kindergarten. To achieve that, FHI focuses on two interim outcomes: reducing parental toxic stress and strengthening family protective factors.

Services for Families/Caregivers

Based on these assumptions, the desired interim and overall outcomes, and in alignment with research findings recommending focus on risk and protective factors, FHI's key strategies reflect the Strengthening Families Protective Factors™ (http://www.cssp.org/reform/strengthening-families):

1. Increase the number of and improve the quality of voluntary **social connections** with kith and kin (through, e.g., Neighborhood Mobilization, Safe Families for Children, and Family Support Workers).
2. Increase **concrete support** (through, e.g., Family Support Workers, Neighbor Connectors, local resources, and Safe Families for Children).
3. Increase **knowledge of parenting and child development** (through, e.g., Family Support Workers and ongoing neighborhood-based developmentally specific parent education classes).
4. Increase **parental resilience**, that is, parent executive function and self-regulation (through, e.g., Family Support Workers, Neighbor Connectors, Safe Families for Children, ongoing parent education, and Behavioral Health Services).
5. Increase caregiver ability to nurture the **social and emotional competence of children** and children's executive function (through, e.g., Family Support Workers, ongoing Parent/Caregiver Education, and Behavioral Health Services).

All interventions take into account that participating caregivers very likely have experienced adverse childhood experiences in their own lives. These early childhood experiences have a significant impact on trust and feeling safe in relationships. Thus, all FHI services are provided with a trauma-informed approach.

FHI works at multiple levels of the social ecology. In addition to the strategies and services to strengthen families, mitigating sources of toxic stress and teaching parents to be more resilient in the face of stress, FHI mobilizes neighborhood residents to connect with each other to promote family protective factors and

thereby make their neighborhood rich in resources that help to strengthen families. FHI also seeks to continuously improve collaboration, quality, and accountability across partners through implementing strategies of collective impact and quality improvement. Finally, at the societal/policy level, FHI advocates for family-friendly public policy that balances the traditional emphasis on disease, disability, and dysfunction with a focus on promoting positive human development, strengthening families, and building neighborhoods; and that pays for outcomes rather than fees for service.

Neighborhood Mobilization Strategies

The Fostering Hope Initiative believes that families—particularly those living in high-poverty neighborhoods—do better when they live in well-connected neighborhoods where residents care about each other and take action to make the neighborhood a safer, friendlier, and better place to raise children. Therefore, FHI includes a strategy to improve neighborhoods, first by engaging residents with each other. However, neighborhood mobilization also includes activities that improve how the neighborhood promotes healthy development and active living, as well as supporting the five Strengthening Families Protective Factors™ (e.g., Does the neighborhood have regular ways to bring neighborhood residents together? Does it have resources to fill a family's concrete needs? Does it offer parenting education within the neighborhood?).

FHI uses four specific approaches to mobilize neighborhoods: Community Cafés, Neighbor Connectors, Neighborhood Activities, and Neighborhood Houses. The neighborhood mobilization strategy, however, begins with connections with people and organizations within each neighborhood. Many of the specific activities developed as a part of mobilizing neighborhoods were simply opportunities that presented themselves because of those relationships or the particular skills and focus of partners working in those neighborhoods. Thus, a Neighborhood Center was developed in one neighborhood because a church partner there had an available building and offered it to FHI. The FHI staff did not go into the neighborhood looking for a neighborhood house, although that could be appropriate. Another neighborhood developed a weekly community dinner in a church that stepped up wanting to do something with FHI to support creating community.

Thus, mobilizing neighborhoods is a combination of good planning, strong neighborhood relationships with organizations and individuals, being alert to unplanned opportunities and how neighborhood resources could be used to promote FHI objectives, and, most importantly, being nimble and flexible enough to follow the lead of neighborhood residents.

Neighbor Connectors. Neighbor Connectors take a positive approach to mobilizing neighborhoods by promoting Strengthening Families Protective Factors™. Connectors communicate with and solicit feedback from neighborhood stakeholders, forming personal relationships with residents through door-to-door introductions, informal surveys, neighborhood events, small groups, and one-on-one

interactions. They identify neighborhood residents who are willing to take action to improve their neighborhood and then support those residents to take action. Although Neighbor Connectors were not a part of the neighborhoods involved with the research project funded by the Center for the Study of Social Policy's Quality Improvement Center on Early Childhood, they have become an important component of FHI.

Friends, family members, neighbors, and community members are able to provide emotional support, help solve problems, offer parenting advice, and give concrete assistance to the caregiver. A Neighbor Connector can act as an instigator for getting individuals together, for sponsoring neighborhood events, and for promoting healthy development. Neighbor Connectors preferably are individuals who live in the target neighborhood. Connectors interact with any and all neighborhood residents and organizations serving the neighborhood. Their primary purposes within FHI are to find pregnant women and families living with toxic stress, and link them with resources; connect neighborhood residents around common interests; reduce social isolation; promote healthy development; and promote safe, nurturing relationships and a stable home.

The concept of Neighbor Connectors is based on the asset-based community development approach to community organizing (McKnight and Block, 2010). This approach looks for common interests among neighborhood residents and uses those to support connections. Thus, Neighbor Connectors identify strengths and needs within neighborhoods, families, organizations, and businesses (ongoing assets and needs mapping) and develop relationships with neighborhood residents, learning about their skills and interests.

FHI Neighbor Connectors primarily are bilingual and bi-cultural, reflecting the demographics of the neighborhoods in which they work. Usually living in the assigned neighborhood, FHI has found that hiring a full-time person—often through a partnership with another organization to share that staff person—has helped to reduce turnover in the position. FHI seeks a neighborhood office space, most often donated by the elementary school or other organization, so residents know where to find the Connector.

Community Cafés. FHI uses Community Cafés (www.thecommunitycafe.com) to create opportunities for neighborhood residents to meet, build relationships, identify common values and interests, take on leadership roles, and agree on strategies for making their neighborhood rich in how it supports family protective factors. Thus, Cafés may discuss any of the five Strengthening Families Protective Factors™ and their presence or absence in their lives and in their neighborhoods. Once Community Cafes are established, Neighbor Connectors encourage vulnerable families who are or have been served by Fostering Hope to attend. FHI's intention is that Cafés are viewed as a group that is available to anyone in the neighborhood—it is NOT a group only for families that need help. Treated as a typical neighborhood event that anyone may join, the Cafés are designed to have no associated stigma.

The process used at Community Cafés is based upon the group facilitation tool, *World Café* (http://www.theworldcafe.com). Community Cafés are a series of guided conversations that are held once each month inside each target neighborhood and typically last about 2 h. At first, Neighbor Connectors facilitate Cafés, but look to develop parent leaders to either take over leadership or co-facilitate the meetings. FHI staff members are available to fill in if there is a gap, but the intention is for the responsibilities related to holding a Café (e.g., facilitation, logistics, food) shift to one or more of its participants. At the end of each Café, the facilitator harvests ideas for actions that could be taken to make their neighborhood rich in supporting the Strengthening Families Protective Factors™.

Based on FHI experience, attendance at Cafés improves when food is served (often a potluck brought by the participants themselves), and tangible goods (such as diapers, children's books, food boxes) are available to distribute at meetings. On-site free child care makes it possible for more families to attend. In the FHI Neighborhoods, Cafés are held in the primary language of the participants. Therefore, Cafés are often held in Spanish only, or English and Spanish, and led by bilingual facilitators. On some occasions, Cafés also have had a sign language and/or Russian interpreter as well.

Neighborhood Activities. Neighborhood-based activities give opportunities for residents to get to know each other—extending their social connections, a key family protective factor. While the primary purpose is to help target families build social connections—an important source of emotional and concrete supports in times of stress—these events often have another purpose as well, including promoting health and healthy eating (e.g., health fair, community gardens, and nutrition and cooking classes), active living (e.g., walking groups, Zumba classes), or kindergarten readiness (e.g., play groups, literacy nights, and early-learning activities). The specific activities are based on the interests of each neighborhood's residents.

Ideas for the activities may come from Community Cafés, FHI staff and partners, or interviews conducted by Neighbor Connectors. Because FHI's purpose is to support the neighborhood to become stronger, we prefer to work with a group of residents and partners to plan and hold the event so that the neighborhood owns the event. Many of the events use resources contributed by partners, such as, food from the local food bank, access to a facility to hold the event, or the development of materials for the event. In every neighborhood, Neighbor Connectors must be open and flexible to take advantage of opportunities that arise.

FHI Neighborhood Houses. An FHI neighborhood house is a physical location that is integrated within the neighborhood, providing a place that gives a local home for the initiative, for Neighbor Connectors, and for holding neighborhood-based activities. A few years after the start of FHI, a church partner in one neighborhood offered FHI a small house that was connected to the church but not being used. Named "La Casita," the house has become the recognized center of activity for FHI in that neighborhood. Students from nearby schools and other volunteers have painted the house, made a sign, built raised beds for gardening, and undertaken many other projects to improve the usefulness of the house in the neighborhood.

Although small, the house is used by partners to hold parenting education classes, gardening groups for children, cooking groups, coffee clubs, play groups, and various other get-togethers. One mom receiving home visiting had goals to do a cooking project and to develop a play group. That interest led to starting a group at La Casita, where they prepare kid-friendly meals and teach their children how to cook. The Neighbor Connector holds Community Cafés there. Partners also use it for partnership meetings or to hold small group or individual therapy sessions with residents, making behavioral health services more accessible for neighborhood residents. La Casita also has a small lending library, and volunteer retired librarians hold story time for children at scheduled times during the week. The local hospital community education department places displays of health information at La Casita, such as on preventing diabetes or understanding child development.

The Center holds activities geared to family and child interests at different times of the day and on most days of the week. The number and duration of activities depend on the initiative's and neighborhood's interest and resources for sponsoring activities.

Recently, an organization in a different neighborhood offered another house for use by FHI as a neighborhood center. FHI worked with partners and neighborhood residents to select a name for the house ("La Placita"), to gather resources for needed maintenance and remodeling work, determine how it will be managed, and plan for how the space will be used. While this house will be the FHI house in that neighborhood, like La Casita, it will very much be "owned" by the residents and FHI partners.

FHI Evaluation Results

Research conducted on FHI from 2010 through 2014 (Dean et al. 2013; Rider et al. 2014) yielded statistically significant differences ($p < 0.05$) on a number of outcome variables. The study employed a quasi-experimental design that included three "treatment" neighborhoods in Marion and Polk Counties, where FHI was active, and three similar "comparison" neighborhoods. The study, funded by the Center for the Study of Social Policy's Quality Improvement Center on Early Childhood, included families with a child under the age of 24 months with no substantiated reports of abuse or neglect at the time of enrollment. Demographic data on participants showed that over 70 % reported an annual income under $30,000; half of the participants had less than a high-school diploma/GED; and the majority of participants were Hispanic/Latino. Program participants received at least 12 months of Healthy Families America home visiting with wraparound support and access to parenting education, Community Cafés, and neighborhood connections.

The data were analyzed using the repeated measures analysis of covariance (ANCOVA), with baseline levels of each outcome variable as the covariate. Relative to families in comparison neighborhoods, families receiving services through FHI reported greater levels of parenting competence and more appropriate

expectations of children. Further, in Marion County, where the collective impact initiative had a stronger history of working collaboratively and a larger neighborhood mobilization effort, families receiving services through FHI reported reduced levels of parenting stress relative to comparison families. This latter result was also found for Hispanic families, regardless of the County in which they lived. The positive results for Hispanic families may be due to the fact that FHI partnered with a local Latino outreach organization, and home-visiting services were provided by bilingual, bicultural staff. In addition, program staff noted that Hispanic families in FHI neighborhoods embraced the neighborhood-based services which were informal and based on an empowerment model.

Advocating for Family-Friendly Public Policy

Because of its use of innovative strategies, most often funded by foundations or donors, FHI has been active in identifying barriers in public policy, practice, and funding mechanisms. While most social service funding is tied to specific diseases, disabilities, or dysfunction, FHI requires flexible funding that allows investment in promoting the positive development of children and adults, strengthening families and mobilizing neighborhoods. The effectiveness of these efforts can be evaluated on the basis of reduced rates of child maltreatment and foster care placement, but the focus is on promoting what is wanted rather than preventing what is not wanted. Therefore, FHI has worked diligently to support funding systems such as social innovation bonds, or "Pay for Success" initiatives in an effort to balance the focus and change the way social services are funded.

In its early days, FHI recruited the Chief Justice of the Oregon Supreme Court to serve as spokesperson for the initiative. From the beginning, FHI was designed to bring some balance to the publicly funded health and human services system that primarily focuses on treatment, intervention and prevention of disease, disability, and dysfunction. FHI instead promotes a more normative approach that focuses on the positive development of children and adults, strengthening families, and building community. This more balanced approach was embraced by families and neighborhood leaders, but at times at the beginning of FHI, it was difficult to get attention and support from service providers and policy makers. This problem was largely solved, however, once the Honorable Paul DeMuniz, then Chief Justice of the Oregon Supreme Court, now retired, agreed to serve as the official spokesperson for the initiative. The Chief Justice was able to bring people together who otherwise might not have joined the effort. He could reach the Governor when needed. In addition, the respect he had earned on both sides of the aisle at the Oregon Legislature assisted us to get the message out to legislators. His involvement with FHI gave the initiative credence in the eyes of policy makers.

A critical public advocacy stance has been that supporting families reduces costs now. It is estimated that the cost of placing one child in foster care for one year in Oregon is $29,000, considering the cost of caseworkers from DHS, protective

service investigations, and the cost of foster care itself. The figure does not include the cost of the other systems that must step in when children fail to thrive in foster care, such as psychiatric hospitals, detention centers, remedial education, mental health services, addiction services, and medical services to restore physical health. FHI believes that strengthening families, promoting optimum child development, and mobilizing neighborhoods will lead to reducing child maltreatment and the costs associated with foster care, remedial education, and poor health. Adding the cost avoidance associated with juvenile justice, adult corrections, and other publicly funded systems of care, the resulting combined resources from these systems could then be used scale-up efforts to promote the positive development of children and adults, strengthen families, and mobilize neighborhoods.

Conclusion

Research supports the efficacy of neighborhood-based approaches, based on significant neighborhood-to-neighborhood differences in the level of child outcomes achieved, the multiple risks in poor neighborhoods that may lead to poor child outcomes, and the nature of social networks and social capital that may be developed within neighborhoods. Each of the programs reviewed in this chapter promotes a focus on high-poverty, distressed neighborhoods to achieve better outcomes for children. Both the Harlem Children's Zone and Promise Neighborhoods emphasize programming, both through schools and community services, that target supports that range from providing parenting education beginning prenatally through support for youth as they attend college and onto a career, while FHI currently focuses on families with children 0-8 years old. All three are based upon the belief that neighborhoods, public agencies, non-profit faith-based and secular organizations, schools, health care, business, parents, and children can work together to create a system of neighborhood services and support that will increase the likelihood that families will be strong and children will reach their full potential.

FHI, however, adds a focus on neighborhood mobilization, employs collective impact to maximize collaboration across service providers, and advocates for family-friendly public policy. All of these are viewed by FHI partners as critical strategies for the long-term improvement in child outcomes.

Having a history of successful collaborations with many organizations critical to achieving the Fostering Hope Initiative vision—including important work with the city, neighborhood associations, community progress teams, funders, parents, and community-based human service organizations—provides a sturdy foundation for current Fostering Hope Initiative collaborations and partnerships.

FHI's strengths lie in its partnerships with other organizations and with neighborhood residents, and in its design that simultaneously addresses multiple levels: supporting families to build family protective factors, mobilizing neighborhoods, strengthening collective impact, and advocating for family-friendly public policy. By taking this approach, FHI has been able to organize supports at several levels for

changing the experience of vulnerable families living in high-poverty neighborhoods.

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Public Policy Strategies to Promote the Well-Being of Families with Young Children

Megan C. Martin

Introduction

Public policy is most successful at meeting the needs of young children when it is created and implemented to also support their parents and caregivers. This is particularly important for young children (birth to age five) who are almost entirely reliant on their parents for nurturing and support. In order for policy to successfully promote positive well-being for young children, the well-being of their families must be considered. Effective policy can increase access to the supports caregivers need to successfully parent and promote the healthy development of their young children. There are a number of policies aimed at meeting the needs of young children and their families. These investments provide important supports ranging from meeting basic needs to promoting stronger relationships between children and their parents. While these investments are critical, research suggests that there are strategies that can be used in combination with these public investments to positively impact the well-being of young children and their parents and to better address currently unmet needs.

Section 1 of this chapter begins by providing information on the demographic characteristics of young children and their families in the United States to better understand the populations that public investments are being made to serve. Section 2 examines select public policies supporting the health and well-being of young children and their families and includes specific public investments in the categories of early learning, health, and family economic stability. Section 3 highlights policy strategies that have the potential to augment current public investments to better support the well-being of families with young children, including strategies to: (a) address opportunity gaps and early disparities, (b) target supports to families living in poverty, (c) adopt supportive work-family policies,

M.C. Martin (✉)
Center for the Study of Social Policy, Washington, DC, USA
e-mail: megan.martin@cssp.org

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(d) create more comprehensive and coordinated support systems, and (f) invest in multi-generational approaches. Section 4, the final section of this chapter, provides an example of a state leveraging current investments with strategies suggested in this chapter to improve child and family well-being.

Section 1: Selected Demographic Characteristics of Young Children in the United States

Young children, defined in this chapter as children under the age of five, make up 6 % of the total population in the United States and account for 27 % of the child population (United States Census Bureau 2013). This age group is increasingly diverse with the following distributions by race and ethnicity: (a) White, non-Hispanic = 50 %; (b) Hispanic or Latino = 26 %; (c) Black, non-Hispanic = 14 %; (d) Asian, non-Hispanic = 5 %; (e) two or more race groups, non-Hispanic = 5 %; and (f) American Indian or Alaska Native, non-Hispanic = 1 % (Harper Browne 2015).

Young children are the most likely cohort of children to live in poor or low-income households. According to the United States Census Bureau, in 2014, 21.1 % of children lived in poverty, with nearly one-half of children under the age of 3 living in poor or low-income households, with incomes below 200 % of the federal poverty level (United States Census Bureau 2013), and 25 % of young children living in poverty. Most states have young child poverty rates at or above 19 % with 10 % of those children living in extreme poverty, in households with income below 50 % of the poverty level. In 20 states and the District of Columbia, the young child poverty rate is above 25 %. For children of color, the poverty rate is even more severe with 38 % of African American children, 33 % of Hispanic children, and 36.8 % of American Indian and Alaska Native children living below the poverty line. The disparities experienced by children of color extend to the youngest children with 71 % of African American infants and toddlers, 67 % of Hispanic infants and toddlers, and 69 % of American Indian and Alaska Native infants and toddlers living in low-income households.

Research shows that living in poverty is associated with heightened risk for factors that have been linked to academic failure and poor health. In 48 states and the District of Columbia, at least 11 % of young children experience multiple risk factors for poor outcomes, including but not limited to living in a household without an English speaker, having a teen mother or having parents who do not have high school degrees. In 2013, 11 % of children had parents who were unemployed, defined as having no employment in the previous year. Between the years 2011 and 2013, a majority of children (54 %) ages three and four did not attend preschool. This number was even higher for low-income children with 63 % of three and four year olds not attending preschool. In 2012, only 30 % of children under age six had received a developmental screening (National Center for Children in Poverty 2013).

This demographic information is an important and necessary starting point to developing policy to best support families with young children as it provides needed context to help identify solutions with the best chance of success and determine which policies are the best investment. For example, because young children, and young children of color in particular, experience poverty at higher rates, more supports are likely to be required to help families meet concrete needs. Policies should also be crafted with a focus on the increasing racial and ethnic diversity of young children and their families, as outlined above, because many disparities in health and well-being begin when children are still very young (Jonson and Theberge 2007).

Section 2: Current Policy Landscape

Demographic information is frequently used in the calculation of the level of funding that a state will receive in federal formula grants as well as to make determinations about other public policy priorities and needed investments. With this as a backdrop, in this section public policies, formula grants, block grants, and tax programs supporting young children will be examined.

Many policies aimed at supporting young children and their families exist; for example, there are policies focused on health care access, preschool quality, food security, and environmental issues including home health hazards. Because young children and their parents are impacted by such a wide range of public policies, this chapter is not intended to be exhaustive, but will focus on advances and opportunities in fundamental policy fields that are specifically aimed at supporting young children and their caregivers. Although these fields are intertwined in many ways, these policies fall into three broad primary categories: (a) early learning, (b) health and well-being, and (c) family economic stability. This section addresses the basic goals of these policies and provides an overview of the current approaches to meeting needs in these areas.

Early Learning

Research shows that opportunities to engage in high-quality early care and education can have a significant positive impact on young children's early learning and their success later in life. Programs that support high-quality early care and education also promote family economic stability through child care while also allowing low-income families to access a higher quality of care than they could otherwise afford (Schmit et al. 2013). The three primary federal programs supporting child care and early education in the United States are the Child Care Development Block Grant (CCDBG), the Temporary Assistance for Needy

Families program (TANF), and Head Start. State funds are also used to support these programs and together amount to a significant investment.

The Child Care Development Block Grant Act was signed into law in November of 2014. This reauthorized the Child Care Development Fund (CCDF) for the first time since 1996 and made significant changes to the program. CCDF provides funds to improve child care quality and is the primary source of federal funding providing child care subsidies for low-income working families. CCDF, as reauthorized under CCDBG, defines health and safety requirements for child care providers, outlines eligibility policies, and ensures more transparent information about child care choices for parents (Office of Child Care 2015). CCDF has a two-generational focus aimed at supporting both school readiness and family economic success. Specifically, CCDF provides access to child care for low-income parents in order for them to work and gain economic independence, while at the same time supporting the long-term development of low-income children by making investments to improve the quality of child care. By making quality child care more affordable for low-income parents, CCDF increases the number of low-income children in high-quality care and strengthens their families' economic security (Golden and Fortuny 2011).

CCDF is administered at the federal level and enables states, territories, and tribes to provide child care subsidies through grants, contracts, and vouchers to low-income families with children under age 13 (Office of Child Care 2015). CCDF is a block grant; states are provided with significant discretion in program implementation and in determining how funds are used to achieve the overall goals of the program. Funding for the program fell slightly in fiscal year 2013 which marked an 11-year low in spending (Schmit and Reeves 2015).

Whereas CCDF is specifically targeted at addressing child care needs, TANF provides funding in the form of a block grant for states to operate their own public welfare programs. States can therefore use TANF dollars in ways designed to meet any of the four policy objectives set out in the federal law, which include: (1) providing assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; (2) ending the dependence of needy parents on government benefits by promoting job preparation, work, and marriage; (3) preventing and reducing the incidence of out-of-wedlock pregnancies and establishing annual numerical goals for preventing and reducing the incidence of these pregnancies; and (4) encouraging the formation and maintenance of two-parent families. The TANF program supports child care for poor and low-income children both through transfers to CCDF (up to 30 % can be transferred to CCDF annually) and by directly funding child care. Because TANF is administered as a block grant, there is no annual limit to the amount of TANF funding that can be allocated for direct child care spending. Accordingly, a state could, for example, decide to devote all of its TANF funds to directly provide child care as a work support for families, or not to spend any of its resources on direct child care expenditures.

Head Start is an early childhood education program that aims to improve social competence, learning skills, health, and the nutrition status of low-income children so that they can begin school on an equal basis with their peers from more economically secure families. Head Start takes a whole-family approach to child care, providing outreach to families in order to connect them to social services and engage parents and caregivers in the planning and implementation of activities. Head Start asks parents to serve on policy councils and committees that make administrative decisions, participate in classes and workshops on child development, and serve as program volunteers (National Head Start Association 2015). The Head Start program is administered by the Administration for Children and Families (ACF). ACF issues federal grants directly to public agencies, private nonprofit and for-profit organizations, tribal governments, and school systems for the purpose of operating local Head Start programs. Federal funding for Head Start increased between FY 2013 and FY 2014 with an appropriation of $8,598,095,000 for programs under the Head Start Act, which represented an increase of approximately $1.025 billion over the fiscal year 2013 funding level (Office of Head Start 2015).

While cumulatively these federal child care programs make a significant investment in early care and education, they still leave a large number of young children unserved. Only 42 % of eligible children are served in Head Start preschool and less than 4 % of eligible children are served in Early Head Start, designed specifically for children under the age of three. Only 26 % of children under age 5 who are federally eligible for child care subsidies through CCDF receive assistance (12 % of infants, 28 % of children ages 1–2, and 30 % of children ages 3–4). However, the largest portion of children benefiting from child care subsidies provided through CCDF are young children (by comparison, 13 % of federally eligible children ages 6–9 and 6 % of federally eligible children ages 10–12 received subsidized care) and come from poor households (Schmit and Reeves 2015). Although eligible children from the lowest income families were the most likely to receive child care assistance through CCDF, the participation rates remain low even for children living in poverty. Roughly 37 % of federally eligible children from families with incomes below the poverty line and 22 % of from families with incomes between 101 and 150 % of poverty were served through the federal child care assistance program (Department of Health and Human Services 2015).

While the current federal programs to support early care and education do not serve all eligible children and families who might benefit from them, they are an important part of the safety net, often providing the only means for participating families to afford child care. Further, there are several important aspects of these programs that research has shown to be beneficial, and that could be included in other public policies aimed at meeting the needs of young families. For example, focusing on the needs of the youngest children living in the households with the highest level of poverty is an important way to ensure that investments are benefiting the families with the greatest level of need (Currie 2001). Engaging parents in leadership roles as well as in daily activities can build important parent–child relationships as well as create additional incentives for parental success both as parents

but as well as in the workforce (Mosel and Patel 2012). Finally, strategies aimed at multi-generational outcomes have been shown to be more successful at meeting both immediate needs and in achieving longer-term educational and employment goals than programs that are child or parent specific (Mosel and Patel 2012).

Health and Well-Being

Improving the health and well-being of young children is in some ways the central goal of all policy aimed at young children and their families. This is particularly the case under the World Health Organization's broad definition of health as being a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity (World Health Organization 2015). Because of this wide scope, the health policy landscape related to young children and their caregivers is vast. Virtually every social program could be construed to have an impact on the health of young children from housing policy to policies related to policing. This section will outline some of the current policy strategies specifically tied to ensuring the health and developmental well-being of young children while acknowledging the significant impact that other policies, not included here may have on the health outcomes of young children. Two programs are outlined here that are targeted at meeting the health needs of young children and their families: the Special Supplemental Nutrition Program for Women Infants and Children (WIC), and the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV).

Established in 1974, WIC provides federal grants to states for supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, as well as for infants and children up to age five who are found to be at nutritional risk. Participants must live in households with incomes below 185 % of the poverty line (in FY 2015, $37,166 for a family of three) (Department of Health and Human Services 2015). Applicants who already receive the Supplemental Nutrition Assistance Program (SNAP), TANF cash assistance, or Medicaid assistance are automatically considered income-eligible for the WIC program. Unlike an entitlement program, such as SNAP, in which funds are guaranteed to be available, WIC funding is dependent upon annual appropriations from Congress. WIC is administered at the federal level by the Food and Nutrition Service at the United States Department of Agriculture and on the state level through WIC state agencies. At the local level WIC services are often provided through hospitals, schools, public housing sites, mobile clinics and Indian Health Service facilities. WIC is one of the largest US policies specifically targeting a single aspect of the health of young children—namely nutrition (Rossin-Slater 2015).

Research indicates that the WIC program has been successful at supporting both young children and their parents across a number of measures. Carlson and Neuberger (2015) examined the impact of the WIC program on low-income

children and families. The benefits of WIC began to accrue even before birth; WIC had an impact on prenatal health and women who participated in WIC gave birth to healthier babies who were more likely to survive infancy. WIC was also found to support more nutritious diets and better infant feeding practices. In particular, Carlson and Neuberger (2015) found that WIC program participants bought and ate more fruits, vegetables, whole grains, and low-fat dairy products. WIC also had an impact on health factors that were not directly tied to nutrition; low-income children participating in WIC were just as likely to be immunized as more affluent children and were more likely to receive preventive medical care than other low-income children. Children whose mothers participated in WIC while pregnant scored higher on assessments of cognitive development at age 2 than similar children whose mothers did not participate, and they later performed better on reading assessments while in school. There are also benefits to low-income communities more broadly that have been attributed to WIC. For instance, improvements made to the WIC food packages in recent years contributed to healthier food environments in low-income neighborhoods, enhancing access to fruits, vegetables, and whole grains for all consumers regardless of whether they participate in the WIC program (Carlson and Neuberger 2015). In addition to the significant investments made to support the nutritional needs of pregnant women and mothers of young children provided through WIC, there are also federal investments aimed at supporting the broader health needs of both pregnant women and mothers with young children.

In 2010, Congress established MIECHV to provide federal funds for home visiting services to "at-risk" families. MIECHV provides supports to pregnant women and families and helps at-risk parents access the resources and develop the skills they need to raise children who are physically, socially, and emotionally healthy and ready to learn. The Health Resources and Services Administration (HRSA), in close partnership with ACF, funds states, territories, and tribal entities to develop and implement voluntary, evidence-based home visiting programs using models that have been shown to both improve child health and to be cost-effective. These programs improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness. ACF also administers the Tribal Home Visiting Program, which funds 25 American Indian and Alaska Native organizations to develop, implement, and evaluate home visiting programs that serve Native children and their families. HRSA-supported State Home Visiting Programs report they have provided more than 1.4 million home visits since 2012 and, in FY 2014, they served approximately 115,500 parents and children in 787 counties in all 50 states, the District of Columbia and five territories. In FY 2015 federal funding for the program was $400 million. According to ZERO TO THREE (2015), every $1 invested in home visiting programs yields up to $9.50 return on investment to society. One of the less well-known strengths of the MIECHV program is its role in enhancing and helping intensify state efforts to create strong systems of services that use public resources efficiently and meet families' needs more effectively. These systems provide a broader setting for the evidence-based, home visiting approaches at the heart of the federal program.

WIC and MIECHV are both programs that research has shown to have significant, positive impacts on young children and their parents, and both have been found to be fiscally sound public investments (Curie and Reichman 2015). MIECHV is an evidence-based and family-specific intervention and WIC provides a host of services related to improving child nutrition outcomes, but both represent comprehensive approaches to meeting the needs of young children. By taking more holistic approaches, both programs have been shown to impact family-well-being across a number of measures.

Family Economic Stability

Policies coming under the heading of Family Economic Stability help families avoid hardships including hunger, substandard housing and untreated illness. These hardships are especially harmful for young children, who are more likely to experience long lasting negative outcomes in the areas of health, social and emotional development, educational attainment, and employment (Brooks-Gunn and Duncan 1997). Research shows that policies aimed at supplementing income are critical in supporting the well-being of young children. Refundable tax credits as well as supplemental income programs that provide direct cash assistance to families have the potential to reduce poverty and positively impact child well-being. The landscape of family economic stability policy includes means-tested benefit programs that provide both supplemental income and in-kind benefits. This section provides a brief overview of the three primary cash transfer programs for working families: the Earned Income Tax Credit (EITC), the Child Tax Credit (CTC), and TANF.

The EITC is a federal tax credit for low- and moderate-income working people. The credit reduces poverty by supplementing the earnings of workers with low wages to provide them with extra financial assistance to meet basic needs. The EITC increases as a worker's compensation rises and encourages and rewards work by offsetting federal payroll and income taxes, most often provided through an annual tax refund. Beginning with the first dollar, a worker's EITC grows with each additional dollar of earnings until the credit reaches the maximum value, which was $5460 for families with two qualifying children in the 2014 tax year. This is intended to create an incentive for people to leave welfare for work and for low-wage workers to increase their work hours. Eligible families use the credit to offset federal payroll and income taxes that disproportionately burden workers in lower income brackets (Center for the Study of Social Policy 2013).

In 2013, about 28 million working individuals and families received the EITC, and more than 6.2 million people were elevated out of poverty, including 3.2 million children. In addition to the federal credit, more than half of the states and the District of Columbia have adopted their own version of the EITC, providing a credit for state taxes. Federal expenditures on the EITC have grown sharply from $5

billion in 1975 to $64 billion in 2012. No other federal antipoverty program has grown so rapidly. The EITC is now the USA's largest cash antipoverty program (Martin and Caminada 2011).

The CTC helps working families offset the cost of raising children. It is worth up to $1000 per eligible child (under age 17 at the end of the tax year). Taxpayers eligible for the credit subtract it from the total amount of federal income taxes they would otherwise owe. For example, if a couple with two qualifying children would owe $4600 in taxes without the credit, they would owe $2600 in taxes with it, because the credit would reduce their tax bill by $1000 for each child (Center on Budget and Policy Priorities 2015). The EITC and CTC are both refundable tax credits, which means that families who have a tax obligation that is lower than their eligible EITC or CTC benefit amount can receive the difference in a refund check from the Internal Revenue Service.

The Temporary Assistance for Needy Families (TANF) program is the primary cash assistance program for low-income families with children. The eligibility threshold, amount of assistance provided, and the eligibility requirements for program participation vary greatly from state to state (Martin and Caminada 2011). Currently, the majority of TANF recipients are children and most TANF caseloads are "child-only," meaning that only the child in the household is receiving assistance. These cases occur when there is no parent in the household or the parent(s) in the household is ineligible for TANF.

In rigorous evaluations of TANF's effects on young children, results have been mixed. Research indicates that when TANF work supports lead to increased education and income for parents their children also show improved educational outcomes. However, one study found that TANF receipt by mothers was associated with negative effects on children's early cognitive development, raising concerns about burdens associated with program participation and the subsequent maternal stress (Child Trends 2015). While the exact causes for this are not clear, TANF has a number of complicated requirements that many families find difficult to navigate as well as sanctions that can be imposed for not meeting those requirements. Individuals who are sanctioned in the TANF program tend to have multiple barriers to employment, suggesting that they are more likely to be unable rather than unwilling to work (Hasenfeld et al. 2004). Outcomes following sanctions include loss of benefits, low or no income, and increased hardship to families with young children, which all could cause maternal stress (Kirzner 2015). The EITC and CTC, on the other hand, do not include any additional requirements outside of the eligibility parameters in the tax programs.

There are several important lessons that should be taken from the family economic stability programs outlined here. Cash transfers through refundable tax credits, like the EITC and CTC, offer an important financial support for low-income working families and their children. These policies both have work requirements for eligibility, but they do not include the often burdensome additional requirements and sanctions that are included in TANF. TANF, because it operates as a block grant with significant program variation from state to state, is difficult to evaluate as

a whole. States have very different programs, some of which are serving families with young children very well and others that are less successful at meeting their needs.

Section 3: Policy Strategies to Better Support Young Children and Their Caregivers

The policies described above are some of the primary public investments in young children and their families. While these policies leave a number of children unserved, they offer important supports and services that promote health, allow for the provision of basic needs, and offset the cost and improve the quality of child care. Unfortunately, the current policy landscape is a patchwork of often disconnected programs that is difficult to navigate for parents. Further, while poor and minority children often face the greatest risks to health and development they also have the greatest unmet needs (Curie and Reichman 2015). The remainder of this paper surveys policy strategies that could be employed within current public investments, including those addressed in the previous section, to enhance their ability to meet the needs of young children and contribute to the development of more responsive early childhood systems. The strategies included here are not comprehensive, but address important and overlapping strategies that, taken together, offer the potential to better support young children and their caregivers, particularly low-income and minority children who represent the largest percentage of young children and have the greatest levels of unmet need.

- *Address Opportunity Gaps and Early Disparities*. Young children in the United States are both the most racially and ethnically diverse age cohort and the most likely age group to experience poverty. In order to ensure both the potential of young children and their parents and to utilize that potential to economic and societal benefit moving forward, public policy strategies need to close the opportunity gaps in early childhood.
- *Target Supports to Families in Poverty*. Resources should be directed to populations with the highest need and which correspondingly derive the greatest benefit from those resources. Research shows that investing in young children both positively impacts child outcomes and is a sound policy investment.
- *Adopt Supportive Work-family Policies*. Policies that allow working families with young children the flexibility they need to navigate life course events such as the arrival of a child or a significant illness can promote family economic stability while also supporting improvements in other measures of parent and child well-being.
- *Create More Comprehensive and Coordinated Support Systems*. Public investments should be made in a way to support comprehensive early childhood systems, enabling families to benefit from coordinated supports and reducing program redundancy and administrative costs.

- *Invest in Multi-Generational Approaches*. Public policy solutions aimed at advancing the needs of young children should always be made with a multi-generational focus. Young children live in families and it is impossible to divorce the circumstances of parents and caregivers from the experiences of their young children. Investing in multi-generational strategies has shown significant promise in better meeting the needs of children and parents long-term with mutually reinforcing benefits.

Address Opportunity Gaps and Early Disparities

Although young children share some universal needs that are important to ensure healthy development, the strategies to support families in helping their young children meet these milestones should be designed to be successful in the particular circumstances of each child. Families live in different neighborhoods, have different experiences, different strengths, and face different challenges. As such, policy should be crafted in ways that take into account these varied experiences, particularly when those differences manifest in significant gaps in opportunities and outcomes. Addressing the opportunity gaps experienced by families with young children living in poverty, with attention to the fact that these families are disproportionately people of color, is important in crafting successful early childhood policy.

Research shows that many disparities in well-being are rooted in early childhood. These disparities reflect gaps in access to services, unequal treatment and exposures in the early years linked to elevated community and family risks (Jonson and Theberge 2007). Young children who experience significant adversity without the supports needed to buffer these experiences can suffer serious lifelong consequences and as such the experience of "toxic stress" is often the root of disparities in health, behavior and economic and educational success (Shonkoff 2013). Poor children are more likely to experience chronic health conditions, mental health problems and educational challenges that can affect their cognitive, social and emotional development (Children's Defense Fund 2015). The poor outcomes experienced by young children living in poverty and the opportunity gaps that lead to those poorer outcomes cumulatively build throughout a child's lifetime. Children born into poverty are more likely to live in poverty throughout their childhood and through adulthood. For example, 49 % of children who are poor at birth are persistently poor (in poverty for at least half of their childhood) compared to only 4 % of children who are not born into poor households (The Urban Institute 2010). Poverty negatively impacts almost every aspect of life for young children and their families. For children of color, the rate of poverty is higher and the consequences of poverty are often more severe.

The opportunities that Black, Latino, and American Indian children have are substantially lower than those of White children because Black, Latino, and

American Indian children, even when they are not poor, are more likely to live in neighborhoods of concentrated poverty (The Annie E. Casey Foundation 2014). As a result, children of color disproportionately live in neighborhoods that have fewer opportunities for quality child care and early education, access to quality health care, safe places to play and healthy and hazard free housing. For example, moving from a high poverty area to a low poverty area is associated with a 50 % increase in the overall availability of outdoor places to play and engage in physical activity. Moreover, communities with higher percentages of African American residents have fewer available parks and green spaces, places to play sports, public pools and beaches (Powell et al. 2004).

In the specific case of healthcare, Curie and Reichman (2015) have made a number of important findings regarding decreased opportunities for poor communities of color. For example, racial and ethnic minority families have an increased likelihood of receiving lower quality health care, regardless of insurance status or income. Moreover, they found that the role of place is just as important in the health context as in the poverty context, where families live strongly impacts their health and well-being and that of their young children. The lack of opportunities available to young children of color and their families has long lasting and significant consequences. Children of color disproportionately miss out on quality educational experiences. Research shows that the center care for African American children in Head Start and non-Head Start programs is consistently rated lower than care received by children of other racial and ethnic groups. Additionally, children in poorer families (of which African American children are disproportionately represented) are more likely to receive care that is rated significantly lower quality than the care their peers receive (Hillemeier et al. 2013).

The disparities in the access to quality care and early childhood education experiences have far-reaching effects. Gaps in cognitive skills are already visible by the time children are 9 months old and tend to become more severe by the time children are 24 months old. These disparities are exacerbated through kindergarten and into elementary school (Department of Health and Human Services 2014). By fourth grade, 83 % of African American children and 78 % of American Indian and Alaska Native children are not reading at proficiency.

Poverty and race must be addressed through an intersectional lens to fully understand the scope of the gaps and to adequately address the needs of the children and families harmed by compounding disadvantages (Crenshaw 2004). The United States is an increasingly racially, culturally, ethnically, and religiously diverse country which brings both benefits and challenges (Cardenas and Treuhaft 2013). As such the creation and implementation of policy and programs aimed at supporting the families of young children should involve strategies that take into account racial, ethnic, and cultural diversity and should be targeted to families in the greatest need of support. There are policy strategies that have shown success in closing opportunity gaps and addressing early disparities. While these strategies have not been applied evenly in early childhood policy, where they have been applied they have improved outcomes for young children and their families and

have shown fiscal dividends through reduced healthcare costs and increased productivity across the life span (Jonson and Theberge 2007).

One foundational strategy to addressing opportunity gaps in public policy and planning is through the collection of more nuanced data. Often systems collect and analyze data in one or two areas; for example, how many families receive child care subsidies and how many of them are African American. These data are also often examined at a particular point in time. A more comprehensive use of data examines information from multiple systems over several different points of time. This approach to data collection and analysis provides a more detailed picture of how children and families of color are faring and allows for a more accurate picture to emerge (Martin and Connelly 2015). More accurate data allow for policy to be created in ways that better meet the needs of families and young children (Martin and Connelly 2015). The better collection and analysis of data is a foundational step toward crafting more responsive public policies. However, there are additional considerations that must be made in order to ensure that young children and their families experience the benefit of public investments.

In order for public policies to successfully address the opportunity gaps for young children and families of color the programs they create have to provide the flexibility and accessibility that families require. This involves both the location of services and supports in places that are accessible to communities of color, and provision of high-quality services that reflect the values and culture of the communities they serve. Examples of programmatic efforts to increase cultural responsiveness include strategies to increase and monitor the cultural and linguistic competency of providers and services, including integrating cross-cultural and cultural and linguistic competency training into early childhood education and health workforce training (Jonson and Theberge 2007).

Examining promising practices and publicly producing findings is an important way to ensure that policies and programs that are closing the opportunity gap for communities of color can move from evidence-informed to evidence-based practices. Developing an evidence base for policies and programs that are most effective for improving outcomes for children and families of color is important to ensuring policy solutions can be scaled and adapted (Martin and Connelly 2015). The use of evidence-based and evidence-informed practices specific to racial and ethnic minorities can promote consistency and equity of care through the use of evidence-based guidelines for health care, early learning, family support, as well as other programs and services targeting families with young children (Jonson and Theberge 2007).

Target Supports to Families in Poverty

Providing for basic concrete needs is a critical part of parenting. Nevertheless, the families of young children in the United States face a number of barriers to achieving this basic goal. As noted earlier, young children experience poverty at

increasingly greater rates, and the impact can be life-long. Children raised in poverty are more likely to experience chronic health conditions, behavioral health problems, and educational challenges among other negative outcomes. Because the economic well-being of children and their parents is inextricably linked, it is important for policy strategies to promote the financial stability of parents with young children.

Unfortunately, while social spending in the United States has grown, recent findings from Moffitt (2015) suggest that there has been a reduction in support to the very poor and to single mother-headed households. While spending for the elderly and the disabled through the US welfare system has increased in recent years, there have been significantly slower increases, if not decreases, in supports for single mothers and their children. Further, Moffitt finds that support for families with the lowest incomes has decreased, but support for those with higher incomes has increased. In fact, Moffitt found that there was a significant shift in welfare spending, from those living in deep poverty—as little as 50 % of the federal poverty line—to those with incomes as much as 200 % above the poverty line. In 2014, a family of four earning $11,925 a year was likely to get less aid than a same-sized family earning $47,700. According to data from the Census Bureau, families living in deep poverty are the families least likely to have access to support from means-tested benefits (including TANF, SNAP and child care subsidies). The data show that 62.4 % of families living at 200 % of the poverty line receive means-tested program benefits, while only 13.8 % of families in deep poverty receive support from these means-tested benefits (Current Population Survey 2014).

Children living in poverty, particularly deep poverty, in the United States are receiving fewer supports and services, while often living in substandard housing and unsafe neighborhoods. Poor families experience more stress in their daily lives than more affluent families, with a host of psychological and developmental consequences. Stress from factors associated with poverty increases the risk of parenting difficulties and can affect parents' ability to meet the needs of their children (Martin and Citrin 2014). When parents struggle to provide day-to-day necessities, they can feel anxious, depressed, fearful and overwhelmed. The daily stress of living in poverty can also have an impact on parenting capacities, resulting in inconsistent discipline, inability to respond to a child's emotional needs or a failure to prevent or address potential risks to safety (Martin and Citrin 2014). Poor families also lack the resources needed to invest in opportunities for their young children such as high-quality child care and enriched learning experiences. Because poor parents are more likely to be raising children alone, work nonstandard hours, and have inflexible work schedules, they often lack the ability to spend time with their children and invest in activities that promote healthy development (Duncan et al. 2014).

There are several strategies that can be used to better meet the needs of low-income families and that target supports to families living in poverty. The majority of the means-tested programs in the United States that provide supplemental income also have work requirements, which means that they are often unsuccessful at meeting the needs of families living in deep poverty (at or below

50 % of the poverty threshold) who often face multiple barriers that prevent them from working in stable jobs (Lei 2013). Means-tested benefits could be structured in ways that ensure the poorest families are able to access them.

One way to improve the effectiveness of means-tested benefits would be to re-examine the role of work requirements. Families living below the poverty line, particularly in deep poverty, often face multiple barriers to work participation. These substantial barriers to work can include homelessness, immigration status, language barriers, chronic illness, addiction and/or physical and intellectual disabilities. While the primary means-tested benefit providing direct cash assistance (TANF) sanctions families facing multiple barriers to work, a parent's inability to meet work requirements could instead be viewed as a red flag for increased family barriers and hardship (Lindhorst and Mancoske 2006). Difficulty meeting program requirements could thus serve as criteria for providing additional supports or special services to address the root causes of non-compliance to programs like TANF and would have the effect of increasing stability in families facing multiple barriers. According to Kirzner (2015) some states have opted to identify and address the needs of parents sanctioned through the TANF program by providing additional supports and services such as transportation and child care to parents who volunteered to participate in work activities. Providing additional supports and services to participants in programs like TANF can both increase a state's participation rate and help families address barriers that are both preventing them from being able to work and increasing family hardship (Kirzner 2015).

In recent years there have been several important changes to safety net programs that have allowed for the families in greatest need to access them. Key changes to the EITC and CTC have strengthened their effectiveness at providing both work-supports and poverty reduction. These changes include marriage penalty relief, a modestly larger EITC for families with three or more children, and allowing low-income workers to start qualifying for the refundable CTC starting at $3000 (rather than the $14,700 that would otherwise be needed to qualify) (Center for Law and Social Policy 2015). However, there are other important changes to the safety net that have the potential to positively impact poor families including expanding the EITC to younger workers starting at age 21 (current eligibility begins at 25) and waiving work and school requirements for TANF recipients for 6 months after giving birth or adopting a child. Changes to the safety net that are specifically aimed at families with young children who are living in poverty is an important step in addressing the significant outcome gaps.

Adopt Supportive Work-Family Policies

The United States is an outlier among other developed countries in its near absence of policies that mandate employee work supports. In addition to the traditional safety net, supportive work policies have the potential to significantly impact poor and low-income parents. Supportive work–family policies are programs sponsored

by workplaces designed to help employees balance work and family roles and include but are not limited to health or stress management programs, Family and Medical Leave Act (FMLA), alternative work arrangements, and dependent care support (Grandey 2001). Unfortunately, such programs are available inconsistently in the United States and are often only available to higher-wage workers. In the US employers have the discretion to determine the family supports provided to employees and to which employees they will extend those benefits. The lack of public policy mandates regarding work support policies, and the subsequent flexibility provided to employers results in low-income workers and single parents, who may be the families that need additional support the most to promote nurturing and care arrangements for their children, as least likely to get such support (Heinrich 2014).

Family-friendly work policies can have far-reaching positive impacts on the development of children. For example, children whose parents return to work sooner after delivery and who spend longer hours at work are less likely to breastfeed. Studies have shown that breastfeeding is associated with lower rates of adult obesity and potentially has effects on neurological development (Chase-Lansdale and Brooks-Gunn 2014). Work policies that do not allow mothers to take sufficient time off after pregnancy can also negatively impact a child's educational attainment. Studies have shown that children whose mothers returned to work earlier within the first year of their life scored lower on school-readiness measures and had lower reading and math scores in school than children whose mothers did not return to work as quickly (Chase-Lansdale and Brooks-Gunn 2014).

In 2014, 58 % of mothers with an infant participated in the labor market as did 64 % of mothers with children under age six (Bureau of Labor Statistics 2015). However, despite the significant growth in labor-force participation by mothers, in both dual income families and by single-working parents, public policy has been slow to institutionalize supports that allow for greater flexibility to care for children without risking family economic security.

There are opportunities through public policy to promote healthier working families and improve child well-being. Policies that support healthy pregnancy encourage women to return to their work if they so choose, and allow for flexibility to care for infants and young children without financial penalties are important in both promoting family economic success and in developing healthy attachment (Heinrich 2014).

Pregnant workers can be penalized for requiring certain accommodations on the job, and these women can even be forced out of, or fired from, their positions (Lyles 2014). Low-income women in the workforce are often more affected by the demands of job duties during pregnancy than are their more affluent peers, since they are more likely to work in jobs with limited flexibility. Women with slightly higher paying jobs in fields that have traditionally been dominated by men, such as policing and trucking, also face multiple obstacles in keeping their employment during and after pregnancy (US Department of Labor 2013). The physical conflict between work and childbearing can lead some mothers to lose their jobs, which

disconnects their families from needed income during a crucial time. When possible, working during pregnancy can allow women to earn additional income and permit women to take a longer period of leave following childbirth—extending the time that mothers can bond with their infants.

Although the federal FMLA guarantees workers leave when they have a child, FMLA only guarantees unpaid leave and only employers with 50 employees or more are required to comply. Many families, particularly low-income and poor families, simply cannot afford to go without income for weeks at a time. Allowing working families the paid leave they need to navigate normal life course events such as the arrival of a child helps to promote attachment without sacrificing family economic stability. Policies that allow parents to work predictable hours, as well as hours that are convenient for family life are also important. Workforce predictability and flexibility allow parents to provide the best and most consistent care for their children and have also been shown to improve a child's developmental and educational outcomes (Venator and Reeves 2014).

Women continue to experience a significant wage gap compared to men. According to the Department of Labor, women earn approximately 81 cents on the dollar, compared to their male counterparts (in weekly wages) and about 77 cents on the dollar when calculations are based on annual earnings (Fortman et al. 2013). This gap equates to hundreds of thousands of dollars in lost wages over the course of a lifetime. The pay gap becomes larger among minority women and women with disabilities (United States Department of Labor 2015). This wage gap has a significant impact on families. Almost 40 % of all households with children include mothers who are either the sole or primary source of income for the family (Wang et al. 2013). Wage equity is an important aspect of supporting working mothers and the impact of these lost wages can be significant for low-income women and single parents.

Making investments in programs that provide work supports to all parents provides opportunities for caregivers to continue in the workforce while supporting their young children. This is particularly important for poor and low-income families who are currently the least likely to receive these supports and whose children face the most significant opportunity gaps.

Create More Comprehensive and Coordinated Support Systems

The policies that guide and fund programs that serve young children and their families are traditionally created in a piecemeal fashion in response to specific needs. Over time, this has created a maze of discrete programs that have conflicting policies, inconsistent quality and accountability, and uneven investments (ZERO TO THREE 2012). This has real consequences for families of young children who are faced with conflicting program rules, uneven access to services, and significant

differences in service quality (Dorn and Lower-Basch 2012). There are a number of ways to support more aligned funding for early childhood systems—from reducing redundancy in a specific policy area to creating early childhood budgets that align fiscal and programmatic information across systems.

Many states and communities are working to bridge the gaps that exist within the array of services available to families raising young children by developing comprehensive early childhood systems. A comprehensive early childhood system provides a coordinated network of services and supports that meet the overall health and developmental needs of young children. As a part of optimizing child outcomes, early childhood systems also include supports for the families of young children aimed at addressing access to housing, jobs, parenting support and education, health care, and mental health services. Public investments can support more comprehensive early childhood systems by (1) coordinating funding streams and aligning the connected policy requirements (2) encouraging partnerships across administrative agencies and service providers and (3) simplifying the eligibility process for families to receive supports.

Strategies that allow funds and resources to be used in more flexible, coordinated, and sustainable ways are critical to the success of efforts to improve the coordination and impact of early childhood systems. Braiding and blending funding streams, allowing for jurisdictions to leverage dollars from federal, state, local and private sources and aligning funding around shared outcomes are all strategic funding strategies that ensure the development of more seamless early childhood systems (ZERO TO THREE 2012). Strategies that blend and braid funding offer flexibility and allow providers to focus on achieving outcomes without the common restrictions that categorical funding streams impose. Both strategies allow funds to be used more easily and creatively at the point of service delivery. However, there are significant differences between blended and braided funding mechanisms. Blended funding pools dollars from multiple sources and makes them in some ways indistinguishable by combining them into one "pot". Braided funding involves multiple funding streams utilized to pay for all of the services needed by a given population, with careful accounting of how every dollar from each stream is spent—separate funds are brought together to pay for services but are accounted for separately for reporting to funders. Research has shown that blending and braiding funding from a variety of sources can enhance coordination, eliminate redundancy, encourage the involvement of multiple-stakeholders and allow for the pooling of a wider range of resources (Association of Government Accountant's Intergovernmental Partnership 2014). Securing funding from braided or blended sources provides administrative agencies with the flexibility to create a package of services that are more likely to meet the needs of participating families. Investments should not only be flexible but should be targeted at developing the infrastructure needed to support comprehensive early childhood systems.

Coordinating funding at the policy level will only be impactful if it is partnered with policy changes that streamline and coordinate programs and service provision. Greater collaboration across administrative agencies and service providers can help to coordinate and align services for young children and their parents. These

partnerships can take a variety of forms ranging from the colocation of child care and work support services to the development of an integrated data system. Programs that incentivize collaboration and cross-sector partnerships between agencies allow for the burden of coordination to be addressed at the system level; reducing the burden ultimately placed on the caregivers of young children.

An important aspect of better coordination is streamlining eligibility to ensure that families of young children are benefitting from the programs that will help support their child's development. Policies that use what is referred to as a "no wrong door" approach are attempting to provide more comprehensive supports and services through a more convenient process allowing families to submit a single form for eligibility to multiple programs. For example, provisions in the Affordable Care Act allow applicants to submit a single application by mail, on line, or over the telephone and the application will be routed to the correct avenue for coverage through, for example, Medicaid, the Children's Health Insurance Program (CHIP), a program that provides matching funds to states for health insurance to families with children, or premium subsidies. In the Affordable Care Act, Express Lane Eligibility allows states to use TANF, SNAP, WIC and free and reduced lunch program as a proxy for Medicaid income determinants for children and adults (Dorn and Lower-Basch 2012)

Using these streamlined eligibility processes for programs make it more convenient for families to access a variety of resources they need and has been shown to increase the numbers of eligible children and families who enroll in such programs. Policies that streamline eligibility have the potential to provide needed supports to families with young children and can have a particularly significant positive impact on families who are poor and low-income. For example, parents who apply to educational or job training programs could be automatically included as people who are potentially interested in high-quality child care services. Reducing the barriers to program participation that often prevent families from applying for needed supports is an important aspect of meeting the needs of young children.

Invest in Multi-generational Approaches

Traditional public policy makes investments in, or primarily in, either adults or children. However, to have a meaningful impact on either young children or their parents it is important to develop strategies that are aimed at meeting their collective needs. Multi-generational policy strategies, also referred to as two-generational or dual generation strategies, are organized to support both parents and young children and to consider the relationship between the success of children and the success of parents. Most of these policies are focused primarily on the needs of either the parent or the child with components to support the other, however, some policies include whole-family strategies that are designed to meet the needs of caregivers and children equally (Mosel and Patel 2012).

An important part of multi-generational strategies is aligning investments in early childhood and in other supportive services for parents. This includes coordinating eligibility policies and program availability so that children can be engaged in developmental activities while their parents participate in mental health services, substance abuse treatment, domestic violence programs, job training, postsecondary education and adult literacy, among other critical programs. Multi-generational strategies are used most frequently in policy serving the families of young children. The combination of services aimed at supporting caregivers and children together is expected to result in a range of outcomes that progressively move the family toward a more economically secure future. These policies have both short and long-term goals, aiming to meet immediate needs and to encourage positive, mutually reinforcing family outcomes over time. For example, parents may be engaging in a program that provides work supports while children are engaged in an early-learning center. As parents achieve academic and economic success over time, they serve as role models for their children and increase their capacity to enrich their children's learning environments and to advocate and support their children in achieving greater academic success (King and Smith 2011).

Research on multi-generational strategies has found that helping parents extend their education could reduce inequality across generations and promoting children's healthy development (Kaushal 2014). Studies have also shown the positive effects of increased education on children's test scores, health, and behavior, as well as on parental behavior that can have a positive impact on their child's well-being, including reducing teenage childbearing and substance use (Kaushal 2014).

Section 4: State Example: Washington State

Communities across the country are beginning to develop more comprehensive ways to meet the needs of families with young children. This section highlights one jurisdiction, Washington State, and the ways the state is leveraging federal investments to develop a comprehensive early childhood system that better meet the needs of young children, with a specific focus on children and families of color. Washington State is investing in the well-being of families with young children by creating more comprehensive, whole-family approaches by leveraging some of the federal investments outlined in this chapter with some of the strategies suggested to improve child and family well-being.

Washington State is working to address early disparities and create a continuum of supports for families with young children through the development of a comprehensive early childhood system including early learning programs and home visiting that are focused on improving the well-being of young children and their parents in ways that better serve communities of color.

The First Peoples, First Steps Alliance is a broad-based alliance that brings together the Department of Early Learning, the Office of Superintendent of Public Instruction, the Department of Health, Tribal leaders, Tribal communities, family advocates, early learning experts and non-Native allies to promote school readiness among Native children and families, with a focus on children from the prenatal period to age 5. Together this partnership is focused on shaping a preschool curriculum to teach early learners about Tribal Sovereignty; keeping Native early learning professionals in classrooms; and support ways that Tribes can utilize current federal funds to prepare Native children for kindergarten in a culturally appropriate way that is consistent with overall federal goals, but flexible in terms of local implementation (Thrive Washington 2015).

Thrive Washington is Washington State's public–private partnership that, with both state and local partners, is working to establish a commitment to deliver a comprehensive, high-quality early learning environment. To address the elimination of opportunity gaps in the implementation of the state's Early Learning Plan (ELP), Thrive Washington released a racial equity theory of change developed by a group of parents, professionals, and policymakers. The racial equity theory of change provides a collaborative vision and approach that supports concerted action among decision-makers at all levels of Washington's early learning system. Washington State uses this tool to identify ways to implement the policies, practices and cultural perspectives that better support children of color.

In 2010, Thrive Washington established a Community Momentum strategy to develop the capacity across the state to create a coordinated system of services and supports that address the needs of young children and their families, especially in communities of color that have historically had the fewest opportunities (Thrive by Five Washington 2012). This coordinated Community Momentum Strategy is a means of setting a common agenda around young children in the state. There are several key components to the Community Momentum Strategy, including the establishment of a governance structure and the necessary partnerships to coordinate the early learning system in different regions. Thrive Washington is working to increase effectiveness and function more consistently across regions by utilizing data to drive decision making, influence program implementation based on regional needs, and align regional efforts to statewide priorities. Additionally, Thrive Washington focuses on building public awareness of the importance of, and increased investment in, early learning by connecting to a variety of stakeholders including parents, local legislators, and business leaders. Thrive Washington is also investing in the creation of an effective outreach platform for state programs, including their Home Visitation program (Thrive Washington 2015).

Washington State has a strong focus on addressing early disparities through their efforts around home visiting and uses a research-driven strategy to implement home visiting programs throughout the state. Thrive by Five Washington, in partnership with the National Implementation Science Network, created an "Implementation

Hub" with dedicated staff to support best practices for the implementation of home visiting programs in Washington State. This "Hub" supports the implementation of home visiting models and ensures their fidelity, provides ongoing program monitoring and technical assistance as well as training and support to the home visiting workforce. This centralized, data-driven support system has provided greater coordination and subsequently has both strengthened services and decreased the duplication of efforts (Center for Law and Social Policy and Center for American Progress 2015a, b).

Washington State is funding their home visitation programs with $1.8 million in MIECHV formula grant funds and $25 million in MIECHV competitive grant funds. Washington State is also supporting this work through state general funds, county-level investments, private investment, and through the implementation of home-based services throughout the state through Early Head Start grantees (Center for Law and Social Policy and Center for American Progress 2015a, b).

Three percent of funds from the MIECHV program are set aside annually in order to meet the needs of Native American families living in tribal communities. The Tribal MIECHV program provides funding to the South Puget Intertribal Planning Agency (SPIPA) which is a tribally chartered intergovernmental agency that provides services, technical assistance, and planning support to each of the five consortium tribes, as well as to eligible Native Americans residing within the SPIPA service area in western Washington. The agency uses MIECHV funds to provide evidence-based home visiting services and build the infrastructure needed to support the programs, which had not been operating prior to MIECHV. MIECHV is the primary source of funding for the SPIPA tribal home visiting program, which has been instrumental in reinvigorating culture and traditions within tribal communities (Center for Law and Social Policy and Center for American Progress 2015a, b).

In an effort to further integrate tribal culture and language into home visiting programs, SPIPA hired home visitors from within their respective tribal communities. Prior to MIECHV, there were no trained paraprofessionals capable of providing home visiting services. To address this, SPIPA conducted intensive training upon hiring home visitors and provided ongoing professional development. SPIPA administrators identified this strategy of hiring from within the tribe and training these new home visitors as a unique opportunity to build professional capacity and create jobs within the tribal communities. Knowing that the home visitors are also members of their tribes has increased the enrollment of families in the program (Center for Law and Social Policy and Center for American Progress 2015a, b).

In sum, Washington State is taking a more comprehensive approach to serving families with young children and is focused on addressing opportunity gaps and early disparities and advancing multi-generational solutions. In order to support this work, the state is utilizing a public–private partnership and leveraging federal, state, local and private funding. The strategy to serve young children and their families in

Washington is one that offers promise for the better utilization of current public investments in young children and the potential of investing in strategies that are aimed at addressing gaps in opportunities and outcomes of children and families of color.

Conclusion

The public policies that serve young children and their parents are wide-ranging. They include policies to advance opportunities for early learning, promote health and establish family economic security. The current investments in these policies are significant, but they still leave a number of young children and families unserved. While additional federal investments to support the current policies serving young children, particularly poor and low-income children are important, it is also important to ensure the services and supports we are providing are optimizing child and family well-being. An aspect of this is ensuring that we are targeting these resources at the families that have the greatest levels of need and ensuring these investments are providing services that are useful, accessible and accommodating to families.

Young children in the United States are increasingly racially and ethnically diverse and are living in poverty at very high rates. Public policies aimed at meeting the needs of young children will be more impactful if they are created in ways that both leverage the strengths of families and appreciate the barriers to their success. The current policy landscape provides important supports and promising opportunities to advance the well-being of families with young children. For the policies that are directly focused on advancing the early learning opportunities, financial stability and health of young children and their parents, research points to several important strategies that can aid in achieving better outcomes.

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From Thought to Action: Bridging the Gap in Early Childhood for Our Most Vulnerable Children and Families

Melissa Lim Brodowski and Shannon Rudisill

Introduction

Support for creating high-quality learning environments for our youngest children from birth to five years old is stronger than ever. Over the last several years, the importance of early care and education has received significant attention from researchers, policy makers, advocates, and state and local programs. A growing body of research on infant and toddler brain development and the critical periods from birth to five years underscore the need for early care and education, family support, prevention, and intervention, especially for children living in low-income families (National Research Council and Institute of Medicine 2000). The first few years of life provide a window of opportunity to build a strong foundation for establishing secure and responsive relationships between parents, caregivers, and their children; these relationships are critical building blocks for optimal health and development, social–emotional well-being, and other positive outcomes for school, work, and later adult life (National Scientific Council on the Developing Child 2010).

The findings and conclusions in this article are those of the authors and do not necessarily represent the official position of the Administration for Children and Families, US Department of Health and Human Services.

M.L. Brodowski (✉)
Office of Early Childhood Development, Administration for Children and Families, US Department of Health and Human Services, Washington, DC, USA
e-mail: melissa.brodowski@acf.hhs.gov

S. Rudisill
Administration for Children and Families, US Department of Health and Human Services, Washington, DC, USA
e-mail: shannon.rudisill@acf.hhs.gov

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Research and practice also underscore the importance of young children having consistent, stable, and loving relationships with parents and caregivers. Early care and education programs offer a vital mechanism for building these positive relationships with non-parental caregivers where many children spend much of their day. Although millions of low-income children are now participating in early care and education programs such as Early Head Start (EHS), Head Start (HS), child care, or preschool, some of the most vulnerable young children and their caregivers who stand to benefit the most from these experiences continue to lack access. Many of these children are experiencing or exposed to multiple adverse childhood experiences, often living in unstable housing and chaotic situations with caregivers who are also experiencing severe and chronic stress, trauma, mental health and substance abuse problems, and interpersonal violence in the home (Child Welfare Information Gateway 2013; National Research Council and Institute of Medicine 2014). These families are often brought to the attention of the child welfare system through reports of suspected child abuse or neglect. Exceptionally stressful experiences early in life may have long-term consequences for a child's learning, behavior, and physical and mental health (Boyce and Maholmes 2013; Grayson 2010).

In addition to strengthening relationships with caregivers, high-quality early care and education programs also present opportunities to buffer the negative effects of adverse childhood experiences and toxic stress. Bridging the gap to ensure that the most vulnerable children and families also have access to, receive, and benefit from high-quality early care and education programs will require a cross-systems approach and a commitment to engaging families and communities in new and more meaningful ways. A number of exciting collaborative efforts have been initiated at the federal level. Although progress has been made, more work is needed to bridge the early care and education gap for children with the greatest needs.

The first part of this chapter reviews the unique needs of the vulnerable young children and families brought to the attention of child welfare. The next section provides emerging evidence of the benefits of early care and education programs to ameliorate the risks and promote protective factors for children and parents experiencing instability and chaos. Federal initiatives will be reviewed including several research and demonstration projects targeted at increasing access to early childhood programs for vulnerable families. The chapter will also review federal policies for strengthening the connections between early care and education, child welfare, and parent, family, and community engagement. A review of the prior lessons learned, ongoing challenges, and future opportunities to promote shared well-being outcomes will be discussed. The final section provides recommendations for a systemic and collaborative approach that links policy, research, practice, and family engagement to bridge the gap in early care and education for all children and families.

The Most Vulnerable Children and Their Caregivers Are Getting Left Further Behind

National estimates suggest that anywhere from 702,000 to 6.6 million children experience or are reported for child abuse and neglect each year (Children's Bureau 2016; Sedlak et al. 2010). Children five years old and younger have the highest rates of child maltreatment with infants one year old or less having the highest rates of victimization for all children 0–18 years (24.4 per 1000 compared to 9.4 per 1000, respectively) (Children's Bureau 2016). Children under age five are also the largest group coming into foster care (Children's Bureau 2015). Three-fourths (75 %) of child maltreatment is the result of neglect (Children's Bureau 2016), and children living in households with severe and chronic neglect are now the majority of families served by the child welfare system. Prior research has demonstrated that neglect is strongly associated with poverty (Jonson-Reid et al. 2013; Sedlak et al. 2010). Children who experience neglect have a greater likelihood of long-lasting negative outcomes than other forms of abuse (National Research Council and Institute of Medicine 2014; Boyce and Maholmes 2013). There is also evidence that certain communities are facing greater disadvantages than others. Black children are living in more disadvantaged communities than white children, which increases the risk for child neglect (Jonson-Reid et al. 2013). This is particularly important in the context of government funded early care and education programs that are prioritized for low-income families.

Certain social conditions are pointing to a need for more urgent action for this population. First, the numbers of children in foster care recently went up for the first time in several years (Children's Bureau 2015), to 415,129 from 401,000. The number of children found to be a victim of child abuse or neglect also increased by 3 % in 2014 (Children's Bureau 2016). Anecdotal evidence points to the increase in heroin and opioid abuse in several states as a primary factor for these increases (Harper 2015). Perinatal substance abuse continues to be a long-standing problem. Each year, an estimated 400,000–440,000 infants (10–11 % of all births) are affected by prenatal alcohol or drug exposure (Young et al. 2009). Other negative outcomes are confirmed by the findings from the Adverse Childhood Experiences Study (ACES),[1] which reveal a powerful relationship between the number of negative experiences reported in childhood and poor adult emotional and physical health. Individuals who reported experiencing four or more ACES had four to twelve times an increase in their risk of multiple negative health problems (including heart disease, diabetes, depression), risky behavior (including smoking, alcoholism, substance abuse, sexually transmitted diseases, unintended pregnancies, and suicide attempts), and even early death (Centers for Disease Control and Prevention 2015) compared to individuals who reported no ACES (Felitti et al.

[1]Adverse childhood experiences include the following: physical neglect, emotional neglect, physical abuse, sexual abuse, emotional abuse, domestic violence, household substance abuse, household mental illness, parental separation/divorce, and incarcerated household member.

1998). More than half of the children brought to the attention of child welfare had four or more adverse childhood experiences, compared to 13 % found in the general population (Stambaugh et al. 2013). Neurobiological research on chronically neglected children has found increased stress response mechanisms in the brain and increased cortisol levels for prolonged periods, which hinder healthy social–emotional development (Sullivan et al. 2013). Children birth to age three who have been maltreated are at substantial risk of experiencing developmental delays. Young children who were maltreated were reported to have high levels of behavior problems as reported by their caregivers (Barth et al. 2007).

Parental mental health and substance abuse challenges are often found among many low-income families served in early childhood and child welfare programs. More than half of the mothers (52 %) in EHS programs reported depressive symptoms that were within the clinical range for depression (National Early Head Start Research and Evaluation Project 2006). One study found that 40 % of mothers with children over two years old, who were investigated by child protective services, reported depressive symptoms within the clinical range at some point over the next three years (Burns et al. 2010; Conron et al. 2009). It is estimated that 11–79 % of families involved with child welfare also have problems with substance abuse (Young et al. 2007). Caregivers who are experiencing multiple problems are especially vulnerable to neglecting their children. Neglected children who experience inadequate parenting often have difficulty forming secure attachments because of inconsistent caregiving, which can contribute to child behavior problems (Manly et al. 2013).

The Benefits of Early Care and Education for Vulnerable Children and Families

The intersection of poverty, neglect, and substance abuse underscores the complexity and urgency for addressing the needs of the vulnerable children and caregivers living in these toxic environments. Children and their caregivers who come to the attention of child welfare have a significant need for prevention, early intervention, and stable and consistent care. These families are also the same low-income families who need high-quality early care and education. The intersection between early care and education and child welfare programs presents a unique opportunity to align shared outcomes focused on well-being and social–emotional mental health to identify, respond, and target the multiple needs of the most vulnerable infants, young children, and their families.

Early childhood interventions are designed to provide a range of services to promote healthy child development and reduce risk factors in the years before school entry. Early care and education enhances child well-being and improves developmental outcomes and school readiness. Early care and education also promotes positive child development, reduces parental stress, and provides linkages to support services (Karoly et al. 2005). A review of early childhood interventions that

addressed cognition and academic achievement, behavioral and emotional competencies, educational progression and attainment, child maltreatment, health, delinquency and crime, social welfare program use, and labor market success found that high-quality early childhood intervention programs can generate benefits that outweigh the program costs (Karoly et al. 2005). High-quality early childhood programs, such as Head Start (HS) and Early Head Start (EHS), enrich the learning and nurturing environments of disadvantaged children (Elango et al. 2015).

Several home visiting programs have also been found to improve outcomes in early childhood and prevent child maltreatment (Howard and Brooks-Gunn 2009). For more than five years, the federal government has supported the scale-up of evidence-based home visiting through the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), which offers support to at-risk parents of children from birth to five years and provides linkages to other early childhood programs and services. One of the home visiting programs that met criteria to be considered evidence-based and eligible for MIECHV funding is Early Head Start–Home Visiting (Administration for Children and Families 2013). Other research on the EHS program found that children who participated in EHS had fewer child welfare encounters between the ages of five and nine years than did children in the control group. EHS children were also less likely to have multiple encounters with child welfare and had a longer time period before subsequent encounters. These findings suggest that EHS may be effective in reducing child maltreatment among low-income children, in particular physical and sexual abuse (Green et al. 2014). Although home visiting is an important strategy for reaching vulnerable parents with young children, the focus of this chapter is on other early care and education programs, including child care, HS/EHS, or other similar programs.

Challenges with Access, Supply, and Quality of Early Care and Education

Despite the inherent benefits, an ongoing challenge is that existing resources cannot provide early care and education services to all the low-income children and families who need them. The current systems of referral and access also do not adequately connect families who are most vulnerable to the highest quality services. EHS only serves 5 % of eligible low-income infants and toddlers, and HS only serves 40 % of eligible four-year-olds across the country (Administration for Children and Families 2014b). The Child Care Development Fund (CCDF) program only provides child care subsidies for 17 % of the eligible children (birth to three years old) in low-income families (Office of Child Care 2015a). In addition, state-funded preschools only serve 29 % of eligible four-year-olds in 40 states (National Institute for Early Education Research 2014).

High-quality early care and education programs—and strong, stable relationships with caregivers—can provide an important buffer from toxic stress and can serve as a key source of stability for children and families facing instability on multiple fronts. Researchers have described instability as "the experience of change in individual or family circumstances where the change is abrupt, involuntary, and/or in a negative direction and thus is more likely to have adverse implications for child development" (Sandstrom and Huerta 2013). Some examples of instability include employment, family, residential, school, and child care. Instability may be caused by a series of events over time, and parents who lack the choices or skills to support their children in adapting to these changes increase risk for negative outcomes (Sandstrom and Huerta 2013). Instability in the family and instability in early care and education often co-occur, disrupting children's relationships with caregiving adults, and undermining the potential benefits.

However, child care instability is frequently a hallmark of young children's lives—as a result of the same factors that affect low-income and vulnerable families. A recent study found that instability in child care arrangements was associated with low-income working mothers' increase in physical and psychological aggression and neglect toward their children (Ha et al. 2015). Another study found that child care instability can have negative effects on children's ability to form social relationships as reported by teachers at prekindergarten. However, some types of instability did not have the same negative effects, particularly for children who only experienced classroom changes within the same child care setting (Bratsch-Hines et al. 2015). The stability of child care placement can buffer some of the negative effects of household chaos (Berry et al. 2016). The research suggests that the frequency of certain types of changes in child care settings may result in greater challenges in adjustments for young children and their caregivers (Berry et al. 2016).

For children involved with child welfare, instability is a common experience and another marker of their increased vulnerability. For children placed into foster care, the lack of stable placements and continuity of caregivers further aggravates the fragile situation. Of the children who were infants at the time of the report of suspected child abuse, 95.4 % had at least one change from infancy and the 5–7 years old range. Within this group, one in four children experienced four or five different placements, and one in seven experienced six or more placement changes from infancy to seven years (Administration for Children and Families 2012). In comparison, the vast majority (89 %) of children who participated in the Early Head Start Research and Evaluation Project who were living below the poverty line did not experience any major changes in caregivers. Only 16 % of these children had a change of caregiver for a week or longer, and most were related to maternal vacations and visits to relatives. Separation was rarely due to the child being removed from the home by child welfare services (Administration for Children and Families 2012).

Government Efforts to Increase Access to Stable, High-Quality Early Care and Education for Low-Income and Vulnerable Populations

Recognizing these gaps in high-quality early childhood services for vulnerable children, ACF has funded a number of research and demonstration projects and technical assistance to learn more about how to take advantage of the intersection of early childhood services with child welfare. The next section will provide an overview of the Quality Improvement Center on Early Childhood. Other initiatives reviewed include the Early Childhood–Child Welfare Partnerships grants, Title IV-E Waiver Demonstration Projects, and Buffering Toxic Stress grants. The following section will highlight several joint policy statements from the Children's Bureau, the Office of Head Start, and the Office of Child Care, which also emphasized the need to work across multiple child-serving systems. More recent opportunities for leveraging collaboration will be discussed including the reauthorization of the CCDF program, the release of the Office of Head Start's Early Learning Outcomes Framework, and other related policy statements from the Administration for Children and Families (ACF), which support children's social–emotional development and well-being.

The Quality Improvement Center on Early Childhood

The Quality Improvement Center on Early Childhood (QIC-EC) was an effort funded by the Children's Bureau from 2008 through 2014 to improve the social, physical, behavioral, cognitive, and emotional well-being of children birth to five years old, and their families, who were at risk of abuse and neglect, including those infants and young children impacted by substance abuse and/or HIV/AIDS. The QIC-EC supported collaborative research and demonstration projects across the child abuse prevention, child welfare, early childhood, and other health, education, and social service systems. The QIC-EC was tasked with generating new knowledge around building protective factors to prevent child maltreatment (Children's Bureau 2008a). The QIC-EC provided funding and support for four research and demonstration projects that tested collaborative interventions designed to increase protective factors, strengthen families, and improve child health and development (see other chapters) (Quality Improvement Center on Early Childhood 2009). One of the unique features of the funded projects was the requirement that strategies had to be designed to improve outcomes at multiple levels of the social ecology: individual, family, and community. The corresponding cross-site evaluation used a systems framework and was designed to measure changes in the patterns of behavior and whether protective factors were built across the QIC-EC projects (InSites 2014).

Embedded in these investments was the core belief that parents, in partnership with other systems of support for their children, were well equipped to provide environments where children can grow, learn, and thrive. Through multiple methods of data collection, including site visits, the cross-site evaluation team identified several guiding practice principles that were used by each of the projects in their approach with families. These included the following: using protective factors as a mental model for decision making and action; creating and building mutually respectful, caring, trusting relationships; addressing disparities in power and privilege; providing flexible and responsive support; and persisting until needs become manageable. Each of the sites also conducted their own local evaluation, which examined whether the projects were able to achieve the expected outcomes. Although the effect sizes were small, the cross-site evaluation found that participants in the treatment groups received more concrete support when they needed it, had higher levels of protective factors, and had fewer negative family interactions than those in the comparison groups (InSites 2014).

Important insights were learned about what is needed to implement these collaborative approaches. Partnerships must be viewed as critical for the intervention. The QIC-EC represented an effort to shift the thinking from risk to promoting protective factors as well as moving toward consideration of multiple levels of the social ecology. Over the life of the projects, the cross-site evaluation found several examples of philosophical shifts in partners who were reframing their approach to working with families toward a more strength-based and protective factor approach. For example, the Strong Start project in Colorado (see Chapter 4, this volume) working with parents involved in substance abuse was able to engage new partners in early intervention and early childhood mental health by shifting their approach. In Oregon, the Fostering Hope Initiative (see Chapter 8, this volume) used the protective factors framework across the agency that housed the project and worked with their state legislature to support this approach. A fundamental and important change was also evident in efforts made to engage parents as essential partners in more authentic ways than the various organizations had been doing before. This required each partnership to include at least one parent in their Advisory Group, and this required changes to basic operating procedures to facilitate more meaningful parent participation in these projects, which were ultimately important for guiding the implementation (InSites 2014).

Early Childhood–Child Welfare Partnerships

For more than a decade, several federal offices within the Administration for Children and Families have been working to address the needs of vulnerable young children and families brought to the attention of child welfare services by disseminating policy and funding to support these collaborative efforts across service systems. One of the first efforts was the Early Head Start/Child Welfare System (EHS/CWS) Initiative, which was implemented from 2002 to 2006. The purpose

was to enhance and expand the service network for children and families involved in the child welfare system and to provide more intensive supplemental services in local communities through EHS that could benefit child welfare populations. The Office of Head Start provided 24 EHS grantees with additional pilot funding to support EHS/CWS programs in identifying optimal strategies for engaging high-risk CWS families. The Children's Bureau funded an evaluation and technical assistance contractor to work with the EHS grantees and produce a final synthesis report on the lessons learned. Grantees generally had positive outcomes related to creating and maintaining safe and stimulating home environments for children, improving families' access to basic medical and social services (particularly immunizations and well-baby/well-child visits), reducing caregivers stress levels by providing direct services or improving coping skills, and enhancing caregivers skills and knowledge of positive parenting behaviors (James Bell Associates 2009).

To further incentivize states and local communities to implement these partnerships, the Children's Bureau issued a funding announcement, "Child Welfare–Early Education Partnerships to Expand Protective Factors for Children with Early Child Welfare Involvement" in 2011 and 2012 to support 18 state and local collaborative projects (Children's Bureau 2012a). The purpose of the grants was to improve the social–emotional and behavioral well-being of infants and children, aged birth to 5 years old, and their families, through collaborative service delivery. Grants were tasked with building infrastructure capacity between child welfare agencies and early childhood systems to ensure that infants and young children in or at-risk of entering foster care have access to comprehensive, high-quality early care and education services (Children's Bureau 2012a).

The grantees adopted a variety of approaches to their projects including developing and/or strengthening community agency partnerships and collaboration; changing policies, procedures, and data systems to facilitate access to enrollment in quality care for foster children; increasing cross-discipline knowledge through training of child welfare and early education staff; expanding the quantity and availability of quality early childhood care offered in the community; collecting and disseminating information; and conducting evaluations of project processes and outcomes (Child Welfare Information Gateway 2015; James Bell Associates 2015).

Title IV-E Waiver Demonstration Projects

Title IV-E Child Welfare Waiver Demonstration Projects gave state child welfare agencies an opportunity to use their foster care funding in more flexible ways to prevent out-of-home placement. Priority consideration was given to states that would test or implement approaches to enhance positive social–emotional well-being outcomes for children, youth, and their families, with particular attention to addressing the trauma experienced by children who have been abused and/or neglected (Children's Bureau 2012c).

More than twenty states have active waiver demonstrations, and at least three states have focused their projects on young children (birth to age five). The Illinois's parenting support demonstration, titled *Illinois Birth to Three* (IB3), targets caregivers and their children aged zero to three years who enter out-of-home placement. Children at risk of or who have experienced physical and psychological trauma as a result of early exposure to maltreatment are a particular focus of this state's demonstration project. In Michigan, the target population for the demonstration project includes families with young children ages zero to five that have been determined by child protective services to be at high and intensive risk for future maltreatment and reside in a participating county. Montana is providing intensive in-home services for children aged zero to five who have been in foster care for less than 60 days, or are at risk of entering foster care, due to neglect. Children and families will receive targeted and intensive concrete supports and interventions for up to six months to allow the children and families to be safely served in the home (James Bell Associates 2014). Each of these efforts are underway; however, it is unclear whether strong linkages have been made to ensure that all children will also have access to high-quality early care and education as part of the waiver demonstrations.

Buffering Toxic Stress

ACF's Office of Planning, Research, and Evaluation (OPRE) awarded six five-year cooperative agreements in September 2011 for "Early Head Start University Partnership Grants: Buffering Children from Toxic Stress." While the grants were not specifically focused on a child welfare population, they do address vulnerable families at risk and offer prevention and early intervention services. The grants have three goals: (1) to identify the children and families most vulnerable to stress; (2) to augment EHS services with parenting interventions aimed at ameliorating the effects of chronic stress on children's development; and (3) to advance applied developmental neuroscience. These grants implemented promising parenting interventions in EHS settings to improve outcomes for the most vulnerable infants and toddlers. Additionally, the six grantees, OPRE staff, and EHS staff from the national office have formed a consortium in which they have identified common measures of risk and protective factors to assess across all of the projects (e.g., socioeconomic status, poverty, and financial hardship; neighborhood characteristics; maternal depression, anxiety, and substance use; and parenting stress). Results from this research will help build a cumulative knowledge base regarding the role EHS can play in promoting parenting practices that buffer children from toxic stress.

Policy Levers to Support Increasing Access to High-Quality Early and Care and Education

The federal government has been committed to increasing investments to improve the quality of early childhood experiences for more children from birth to five years old. Recent investments expanded support for the Maternal, Infant, and Early Childhood Home Visiting for families with children from prenatal to five years; growing the supply of high-quality early learning opportunities through the Early Head Start–Child Care Partnerships for children birth to age three; and PreSchool Development Grants to help states offer preschool to more children between four and five years before they enter kindergarten (Administration for Children and Families 2014a). Within the US Department of Health and Human Services, the Administration for Children and Families' Office of Early Childhood Development oversees programs managed by the Office of Head Start and the Office of Child Care. ACF's key priorities are increasing and maintaining the supply of high-quality early learning opportunities through a number of programs including EHS, HS, and the Child Care and Development Fund Block Grant (CCDF).

HHS Policy Guidance—To highlight the continued support for early childhood and child welfare partnerships, the Children's Bureau, the Office of Head Start, and the Office of Child Care issued joint information memoranda to encourage collaborations in early care and education for children involved with child welfare. The first Information Memorandum was issued in 2010 to HS and EHS grantees to reinforce the commitment to serving abused and neglected children and to provide guidance regarding promising practices in recruiting and serving families involved in the public child welfare system (Office of Head Start 2010). The second Information Memorandum was issued in 2011 to state and local child welfare agencies to reinforce the Children's Bureau commitment to supporting child welfare agencies' investment in partnerships with HS and EHS agencies in order to improve young children's access to and continuity of comprehensive, high-quality early care and education services (Children's Bureau 2011). A third Information Memorandum was issued in 2011 to CCDF state agencies and state and local child welfare agencies to encourage partnerships across these agencies to better serve vulnerable child populations and families (Office of Child Care 2011). Each memorandum provided specific strategies and resources for collaboration, cross-training, and increasing access to quality early care and education.

Statutory and Regulatory Opportunities—There are a number of opportunities for state and local jurisdictions to use current and proposed changes in federal policies and standards to reinvigorate their efforts to serve the most vulnerable children and families. Currently, children who are in need of protective services, as defined by the state or territory, are categorically eligible for child care subsidy receipt at the discretion of the state or territory. CCDF agencies may prioritize child care subsidies for children in protective services and indeed have initiated

innovative partnerships to meet the needs of this population (Office of Child Care 2011). At least 26 states and territories prioritize eligibility for CCDF child care subsidies for children receiving or in need of protective services. Additionally, many states also elect to waive, on a case-by-case basis, the family fee and income eligibility requirements for cases in which children receive, or need to receive, protective services (Office of Child Care 2015d Data Explorer).

The reauthorized Child Care and Development Block Grant (CCDBG) Act of 2014 makes expansive changes to CCDF focused on improving the health and safety of children in child care, improving child care subsidy policy for families and providers, promoting consumer education, and improving the overall quality of child care and afterschool programs to support children's development and learning (Office of Child Care 2015d). A key change in the law is a requirement for a minimum 12 months of eligibility for child care assistance. In the past, burdensome eligibility and administrative requirements caused many families to lose care even when they were eligible, adding to the instability in already stressful lives. The new statute includes the 12-month minimum and other provisions to stabilize families' access to child care assistance and, in turn, to create more long-term relationships with caregivers. State CCDF agencies are also required to prioritize investments that increase access to high-quality child care services for children in areas that have significant concentrations of poverty and unemployment and that lack high-quality child care services (Office of Child Care 2015d). Focusing on these areas may provide opportunities to prioritize children that come to the attention of child welfare who are likely also living in these high poverty areas.

Head Start regulations specify that foster children are categorically eligible for the program, even if the family income exceeds the income guidelines. Through the previously mentioned Information Memorandum issued in 2010, the Office of Head Start has encouraged grantees to prioritize children in the public child welfare system when establishing selection criteria for services. Children who are still placed at home but have an open case with the child welfare system are not categorically eligible for Head Start. However, a program may decide to prioritize these children for enrollment due to the level of risk and the needs of the family (Office of Head Start 2010).

The Office of Head Start recently issued proposed standards for EHS/HS programs that offer grantees the opportunity to more effectively serve vulnerable children such as those experiencing homelessness or placed in foster care. The Office of Head Start has proposed an option which allows programs to reserve up to three percent of their slots for children experiencing homelessness or who are in foster care (Office of Child Care 2015b). Given the instability of these children's living situations, if these proposed standards remain in the final rule, reserving these slots will allow grantees greater flexibility to serve a more vulnerable population and may encourage more grantees to prioritize these children for services.

Fostering Connections

One model for promoting continuity of care in early childhood is the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110-351). One of the provisions of this law focused on educational stability for school-aged children in foster care. The law amends the child welfare case plan provisions by adding Section 475(1)(G) to require a plan for ensuring the educational stability of the child in foster care. The law also amended the definition of a "foster care maintenance payment" in Section 475(4) of the Act to include the cost of reasonable travel for the child to remain in the same school he or she was attending prior to placement in foster care. The law requires child welfare agencies to assure that they have coordinated with appropriate local education agencies in developing their plans (Children's Bureau 2008b). Though the focus of educational stability was on school-aged children, a similar strategy and approach could be adapted for children under five years old and emphasize the need for stability in early care and education settings.

Challenges and Opportunities

Despite the concerted attention and effort over the last several years, the number of children in child welfare who are served through early care and education programs remains low. Although children in foster care are categorically eligible for EHS/HS, only 2 % of all children served fall into this category and this number has remained unchanged for the last five years (Office of Head Start 2015a, b, c). Approximately 10–13 % of children in EHS/HS were also reported to be involved with child protective services, a number that has also been relatively stable over the same time period (Office of Head Start 2015a, b, c). A few studies suggest that foster children use child care subsidies at lower rates than other low-income families, with estimates ranging from 11 to 13 % compared to 30 % of income-eligible parents who used subsidies (Lipscomb et al. 2012). Child care subsidy receipt also does not guarantee that services available will be of high-quality (Johnson and Ryan 2015). In addition, among low-income subsidy-eligible families, those with higher incomes or income-to-needs ratios were more likely to receive a subsidy than more disadvantaged families (Fory et al. 2013). In both the CCDBG reauthorization and the proposed Head Start standards, state and local programs have the opportunity to partner across multiple systems to better meet the needs of the most vulnerable children and families. Applying for programs and maintaining attendance and enrollment—especially in the unstable child care program—can be challenging to navigate for many families. These challenges are compounded by the stressors faced by highly vulnerable and unstable families. State and local agencies can work together to take advantage of policy options, caseworkers, and family support workers, to ease enrollment and maintain enrollment and attendance.

Lessons learned from the Early Childhood–Child Welfare Partnerships point to the complexities and challenges of building and sustaining the infrastructure to prioritize vulnerable children for early care and education services. The lessons learned from the QIC-EC also reinforce the need to understand factors that support changes in behavior at the individual, family, and community levels and ensure that parents are fully engaged in these efforts. However, meaningful and authentic partnerships to build bridges across multiple systems often take much longer than originally anticipated and are difficult to sustain.

At the systems level, grantees increased the capacity of EHS staff to work with children and families involved in the child welfare system and promoting inter-organizational awareness and collaboration among EHS and local child welfare and other human service agencies. However, maintaining positive long-term outcomes has been more challenging. The families' inconsistent follow-through with services that were recommended was a common implementation barrier. As with all collaborative efforts, successful partnerships required considerable investments of time, effort, human, and fiscal resources and become hard to sustain with changing leadership and program priorities (James Bell Associates 2009).

Although data clearly point to the need for more early care and education services for this vulnerable population, lessons learned from the Early Childhood–Child Welfare Partnerships point to a number of systemic and structural issues that created barriers to implementation. For example, a majority of the grantees uncovered issues in child welfare and early care and education (ECE) data management systems that hindered foster child referral and enrollment (James Bell Associates 2015). Four grantees focused on improvements to data management systems to increase referrals to address challenges related to tracking of foster children for ECE eligibility; interoperability of child welfare and ECE systems; and identification of quality programs.

Several grantees identified other structural barriers to foster child participation in ECE including voucher distribution and information sharing limitations. Child welfare workers did not know that foster children were categorically eligible for EHS/HS and had misperceptions of EHS/HS services. There were no easy or automated referral systems for foster children to EHS/HS or other high-quality ECE programs, and there were challenges to the development of such systems. The typical school-year enrollment periods and school-day schedules for EHS/HS were not compatible with year-round, full-day needs for foster children and working foster parents. EHS/HS programs were at capacity and could not accommodate new foster children, or they may have been inconveniently located for foster parents. There were difficulties identifying high-quality programs, due to a lack of universally available, widely used quality ratings for ECE programs. Grantees found inadequate information exchange between ECE providers and caseworkers regarding children's needs and progress (James Bell Associates 2015). Some of these issues were addressed through cross-trainings and changes to data systems, while other changes required adaptations to organizational policies and processes.

Several grantees also sought to influence state policies to facilitate the enrollment of foster children in ECE. For example, Arkansas identified a systemic issue in

voucher distribution that was causing interruptions in foster child participation in ECE and sought to improve it. Essentially, vouchers for foster children were typically awarded to the child care provider, which caused disruption because each time the child's placement changed, a new voucher would have to be applied for and awarded. This state agreed to revise this procedure so the voucher could be awarded to the foster child and follow the child through changes in child care providers and/or child welfare placements (Lloyd and Dejohn 2013). Connecticut formed a statewide early childhood community of practice to review policy as it relates to children in child welfare. Each of the grantees worked on organizational and systems changes at multiple levels, and many were continuing to work on these issues even after the end of their 17–24 month grants (James Bell Associates 2015).

Focusing on Social–Emotional Well-Being for the Most Vulnerable Children and Families

Key leverage points across these systems are the shared goals to support the healthy development and social–emotional well-being of young children and their families. HS and EHS have a long-standing priority to address and support the social and emotional development of children in their programs. The recently released Head Start Early Learning Outcomes Framework underscores the importance of positive social and emotional development in the early years for lifelong development and learning. Key to this domain is a child's ability to create and sustain meaningful relationships with adults and other children. These positive relationships also foster problem-solving skills as young children navigate interactions with their peers (Office of Child Care 2015c). In this way, HS/EHS programs and curriculum are intentionally structured to help children develop critical social skills, such as compromise, cooperation, and sharing, which are needed for later success and positive outcomes in adulthood (Office of Child Care 2015c; Jones et al. 2015).

The focus on social–emotional well-being is a more recent priority for child welfare. While the key outcomes for the Children's Bureau are still focused on safety, permanency, and well-being, the Children's Bureau Information Memorandum on Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services underscored the central importance of social and emotional well-being. The memorandum encouraged state child welfare agencies to focus on social and emotional well-being and implement effective programs and strategies that could attend to children's behavioral, emotional, and social functioning. Guided by the research on child health and development, trauma, and toxic stress, the framework identified four basic domains of well-being: (a) cognitive functioning, (b) physical health and development, (c) behavioral/emotional functioning, and (d) social functioning. These domains were based on the body of research that has clearly demonstrated the profound impact that maltreatment has on children's development. The guidance encouraged

agencies to re-examine child welfare policies, programs, and practices and give greater consideration to explicit efforts to reduce problem behaviors and improve child functioning (Children's Bureau 2012b).

Finally, the Office of Child Care recently issued an Information Memorandum on state policies to promote social–emotional and behavioral health of young children in child care settings in partnership with families (Office of Child Care 2015b). The CCDBG Act of 2014 makes several references to children's social–emotional and behavioral health. The act requires states to provide consumer education information to families, the general public, and, where applicable, providers. That information must include their "policies regarding the social–emotional and behavioral health of young children, which may include positive behavioral intervention and support models and policies on expulsion of preschool-aged children, in early childhood programs receiving [CCDF] assistance." The law also specifies that CCDF quality enhancement funds be used for professional development, including effective behavior management strategies and training that promote children's social–emotional development, which are all opportunities for focusing on the needs of the most vulnerable children and families (Office of Child Care 2015b). Child care providers have a tremendous opportunity to promote children's social–emotional and behavioral development and enhance parenting skills that support healthy and secure relationships. The guidance provides suggestions for policies and practices for building the workforce capacity, implementing technical assistance and mental health consultation models, and strengthening quality rating systems and early learning guidelines (Office of Child Care 2015b).

Parent, Family, and Community Engagement as Levers for Change

An important lever of change rests with the parent, family, and their community. Parent engagement is a key feature of EHS and HS programs and a growing emphasis for many early childhood programs. Fundamentally, when program staff and families are engaged as partners, they commit to working together on children's behalf. The Office of Head Start's Parent, Family, and Community Engagement (PFCE) Framework emphasizes the importance of systemic, integrated, and comprehensive approaches to family engagement in the organization or system, over random acts of family engagement. The PFCE Framework identifies the program service elements that contribute to family and child outcomes including the program environment, family partnerships, teaching and learning, and community partnerships. This approach, along with positive goal-directed relationships between families and program staff drive and support family well-being, family engagement, and children's school readiness (Office of Child Care 2011). Effective

family engagement is built on responsive, reciprocal, and respectful relationships with families. For caregivers experiencing stress and trauma, early care and education providers will need to make concerted efforts to engage these families in new and different ways.

While the PFCE Framework was created to help EHS/HS programs meet federal performance requirements and achieve school readiness outcomes, other family engagement frameworks have been applied to a broader early care and education settings and embedded into state Quality Rating and Improvement Systems (QRIS). Strengthening Families helps early childhood programs identify concrete and specific ways to engage and support parents and caregivers and is framed around five protective factors demonstrated by research to be linked to optimal child development and reduced rates of child abuse and neglect. In most states, Strengthening Families are being implemented across many systems including early childhood, family support, child abuse and neglect prevention, child welfare, and children's health and mental health. Nine states are using Strengthening Families tools within their Quality Rating and Improvement Systems (QRIS) and at least six are in the planning phases. Several HS programs and child care programs also use the Strengthening Families framework in their programs. Work is also underway to map the alignment between the Strengthening Families framework, the HS PFCE Framework, and the HS program performance measures (Center for the Study of Social Policy 2013). These efforts provide other opportunities to incorporate parent and family engagement in more intentional ways across a number of early childhood programs.

Building on Lessons Learned to Bridge the Gap in Early Care and Education for Vulnerable Children and Families

ACF's broad vision for early childhood is increasing the supply, quality, and continuity of early learning environments for young children in the zero to five age range and their families. Although progress has been made, more work is needed to ensure that the most vulnerable children and families, especially who are at greatest risk of neglect and brought to the attention of the child welfare system, have the opportunity to benefit from high-quality early care and education. There are exciting opportunities to do more to align work that is happening in child welfare and early childhood policy, practice, and research to better serve the needs of our most vulnerable children. The focus on protective factors creates a common language and can create benefits at a broad scale for families all along a spectrum of risk. The importance of continuity of relationships in the early years also provides another common foundation in early care and education. The emphasis on educational continuity in Fostering Connections for child welfare provides a starting point for moving this policy toward children under five years.

Supporting Cross-Agency Partnerships by Leveraging Shared Outcomes

The experience of the QIC-EC and the Early Childhood–Child Welfare Partnerships grants demonstrates that translating policy to practice requires a systemic approach that engages parents, staff, agency administrators, and other key stakeholders in shaping the priorities and the services available for vulnerable families. First, leadership needs to prioritize cross-systems collaboration and the need to understand each other's systems and accept shared responsibility for improving outcomes for families. There is an ongoing need to build awareness among child welfare staff about the importance of and resources available from early care and education. Conversely, there is also a need for awareness building with early care and education about the importance of prioritizing and serving children who come in contact with child welfare.

Child welfare systems-level initiatives such as the Title IV-E Waiver Demonstration Projects and differential response present strategic opportunities for policy alignment with early care and education efforts. Title IV-E Waiver Demonstration Projects emphasize the use of functional assessments, including health and development screening, to guide evidence-based services that should be provided for children in child welfare. Differential response is a practice model for child protective services and investigations which emphasizes family engagement, comprehensive assessments of their strengths and capacities, and the provision of services to keep families together (Quality Improvement Center on Differential Response 2014). The IV-E Demonstration Projects and differential response present large-scale demonstration efforts that are testing the scale-up and implementation of different strategies to prevent more costly foster placements and provide services to keep children safely at home. The Child and Family Services Reviews is an outcome-focused monitoring system that also examines the extent to which child welfare agencies and key partners in the state are providing the services that families need to enhance the safety, permanency, and well-being for their children. These efforts present opportunities to identify policy levers and data-sharing initiatives that can be used to ensure that all children from birth to age five can be referred for early childhood services when they have been brought to the attention of child welfare. A careful analysis of the referral and intake processes across systems can identify structural barriers and potential solutions to increase access to early care and education services for families that have the greatest needs.

Next, the workforce needs to have the skills and capacity to meet the needs of children and families living with chronic neglect and other adverse childhood experiences. The proposed new CCDF regulations and HS standards maintain a priority for this population. Staff working in early education settings need to respond to the health, social, emotional, and behavioral needs of children and caregivers impacted by trauma, toxic stress, and other adversities. Teachers will need training and professional development opportunities that include adequate supervision and coaching on evidence-based strategies and curriculum to address

these needs. On the child welfare side, workers will need more support for ensuring that infants and young children are systematically identified, assessed, referred, and receive high-quality early care and education. Foster parents will also need support navigating the services and resources that are available to foster children. Agencies will need new ways of reaching the most vulnerable children and families to ensure that they are fully engaged and are retained in early care and education programs.

Lessons learned from the Early Childhood–Child Welfare infrastructure grants demonstrate that this does not always translate into policy and practice that gets widespread implementation or is sustained over the long term. Concerted efforts should be made to navigate the barriers and develop specific recommendations for referral and training systems at the state and local level that build upon prior efforts. ACF recognizes the importance of this specialized expertise and should build upon cross-training efforts across multiple systems. ACF recently partnered with the Substance Abuse and Mental Health Services Administration on their National Center of Excellence for Infant and Early Childhood Mental Health Consultation to build capacity of early childhood professionals to attend to these needs (Oppenheim 2015).

Recent guidance from the Office of Child Care on children's social–emotional and behavioral health recommends that early childhood educator preparation and other training programs incorporate the latest research-informed content on social–emotional development, trauma, family engagement, child screenings and referrals to specialized services, and positive behavioral guidance. States should ensure that child care and other early childhood programs train their staff to recognize behaviors typical of young children who have experienced trauma and have the skills and competencies to create settings that are responsive to the needs of traumatized children. Training topics may include identifying trauma in young children, developmental and behavioral screening, fostering social–emotional development, implementing positive behavior management strategies, fostering secure attachments with young children, delivering culturally competent services, and building self-reflective strategies to identify and correct potential biases in interactions with children and their families (Office of Child Care 2015c; U.S. Department of Health and Human Services 2014). Training for early care and education providers should recognize that some caregivers have also experienced similar traumatic and stressful experiences as the children and families they are serving. Gilbert (2016) describes this as the "mirroring of disadvantage in child care settings" and will require a more inclusive and comprehensive approach to responding to the needs of vulnerable children and families, and the providers working with them. States should work with their partners across multiple agencies to leverage training funding that may be available from child welfare or other systems to increase the capacity of early care and education providers to better meet the needs of children involved with child welfare.

Finally, family support workers, and child welfare case managers can provide needed advocacy and support for caregivers and children living in chaotic and unstable situations. Parent engagement strategies will need to be comprehensive and integrated with other early childhood and family support services offered to the

family. In order for parents to have the capacity to provide care and ensure that their children have the best opportunities to grow and thrive, they need to also be living in communities that provide them with adequate support and have access to high-quality early care and education for their children. Indeed, the power and promise of nurturing environments to support positive outcomes is clear (Biglan et al. 2012).

Conclusion

To address the needs of children and families with multiple and complex system involvement, deeper partnerships and a shared responsibility will need to be established and maintained. No single agency has all the resources, the expertise, or the capacity to address the full range of needs of all these young children and their families. Bridging the gap to meet the needs of the most vulnerable children and families requires a multi-level strategy that ensures strategic connections across leadership, policy, research, and practice. Parent, family, and community engagement strategies must be used to foster and sustain these connections across multiple levels of the service system. There have been great strides in fostering partnerships across early childhood and child welfare, and these efforts will need to continue to evolve and adapt with new early childhood policy opportunities. We must continue to learn from prior work, generate new knowledge, and use that information for ongoing learning and continuous quality improvement. There is an exciting synergy across multiple child and family systems working toward optimal child health and development, social–emotional well-being, and high-quality early learning opportunities.

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