PATHWAYS TO EARLY SCHOOL SUCCESS ISSUE BRIEF NO. 1

Helping the Most Vulnerable Infants, Toddlers, and Their Families

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NCCP National Center for Children in Poverty
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The National Center for Children in Poverty (NCCP) is the nation's leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Founded in 1989 as a division of the Mailman School of Public Health at Columbia University, NCCP is a nonpartisan, public interest research organization.

Pathways to Early School Success—Issue Brief No. 1
Helping the Most Vulnerable Infants, Toddlers, and Their Families

by Jane Knitzer and Jill Lefkowitz

This document builds on NCCP's work over the past several years to describe effective programs, highlight policy opportunities, and offer fiscal strategies to promote the emotional health and school success of young children and their families. (See Promoting the Emotional Well-Being of Children and Families series, at www.nccp.org and also Promoting the Well-Being of Infants, Toddlers, and Their Families: Innovative Community and State Strategies, at www.nccp.org/it_index.html.) These analyses will help policymakers, community leaders, and advocates take action to ensure the healthy development of children and their families. Companion documents focus on fiscal strategies to maximize existing funding streams (*Spending Smarter: A Funding Guide for Policymakers and Advocates to Promote Social and Emotional Health and School Readiness*) and targeted interventions that can help parents and other early care providers be more effective in promoting healthy relationships and reducing challenging behavior in infants, toddlers, and preschoolers (*Resources to Promote Social and Emotional Health and School Readiness in Young Children and Families—A Community Guide*). Many of the specific programs described in this document are more fully detailed in the latter guide.

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Executive Summary

Compelling evidence from neuroscience about how early relationships and experience influence the architecture of the brain,[1] and in turn early school success, has led to increasing policy and practice attention to implementing child development and family support programs like Early Head Start for infants and toddlers.

But, there is also a group of babies, toddlers, and parents who face so many risks that programs like these alone may not be enough. This issue brief focuses on the special challenges of helping babies and toddlers whose earliest experiences, environments, and especially relationships create not a warm and nurturing atmosphere, but what scientists have called "toxic stress"—exposing them to such high and consistent levels of stress that their growing brains cannot integrate their experiences in ways that promote growth and learning. It describes 10 strategies that programs and communities can implement to ensure these babies, toddlers, and families are connected to sufficiently intensive supports that can get them on a path to early school success.

Defining Vulnerability: Empirically-based Approaches

Given the challenge of using scarce resources for these infants and toddlers in the most effective way, it is important to define the parameters for vulnerability with even more specificity. Currently, there are three approaches to identifying levels of risk in young children, all based in some way on empirical and theoretical developmental science:

- Risk indices that reflect some combination of demographic, child, family, and environmental risks, for example, being a single parent, receiving public assistance, being neither employed nor in school or in job training, being a teenage parent, and lacking a high school diploma or GED. Twenty-six percent of the families enrolled in Early Head Start experienced four or more of these risk factors. That sub-sample of Early Head Start families did not benefit from the program in the same way that other families did.[2]
- Identifying young children in circumstances known to place them at risk by virtue of their exposure to ineffective parenting or parental absence. These include:
  - The more than 150,000 young children under age 6 in foster care in 2003, including 25,000 infants.[3]

- Over 300,000 young children with incarcerated parents (half of whom are infants and toddlers).[4]
- An estimated 550,000 young children in homeless families.[5] (There are no separate figures for infants and toddlers.)
- The just over 175,000 infants and toddlers who were victims of substantiated abuse and neglect in 2003. (Infants and toddlers have the highest rate of victim investigations—16.4 per 1,000—and are most likely to suffer a recurrence.)[6]

- Using prevalence data based on parental risk factors known to impair effective parenting. Impaired parenting—defined as harsh, inconsistent, or indifferent parenting—is known to be related to poor developmental and emotional outcomes in young children.[7] Factors that place young children at serious risk for such parenting include maternal depression, substance abuse, domestic violence, and—although we lack even estimates of national prevalence rates—the parents' own unaddressed childhood or current trauma. A prevalence-based parental risk perspective includes:
  - The estimated 10 percent of all young children who live with parental substance abuse/dependence.[8]
  - The estimated 1.4 million to 4.2 million young children who experience domestic violence.[9]
  - Young children whose parents have either clinically diagnosed or clinically significant symptoms of depression, often with other risks as well. For example, in a recent study of Early Head Start parents, a stunning 48 percent of the parents had depressive symptoms.[10]

Appropriate Goals for Interventions Targeted to the More Vulnerable Infants, Toddlers, and Families

Even in the most high-risk families, unless a child's safety is at stake, the best way to promote healthy development and reduce risks is to help the baby's parents and other caregivers. In general, research supports an integrated four-pronged approach:

- Promote healthy, effective parenting responsive to complex parental risks.
- Provide interventions that explicitly address parental risk factors.
- Connect babies and toddlers with necessary health and related services.
- Address the concrete needs of the family.

Ten Strategies to Help Infants, Toddlers, and Families at Higher Risk for Poor Outcomes

Strategy 1: Ensure that ALL low-income families have access to infant and toddler child development and family support programs.

Strategy 2: Embed research-informed intensive interventions, such as parent therapies, into Early Head Start and home visiting infant and toddler child development and family support programs.

Strategy 3: Embed intensive interventions for infants and toddlers and their families in settings serving only high-risk families.

Strategy 4: Organize services by level of family risk.

Strategy 5: Use basic support programs for families to provide more intensive services.

Strategy 6: Build partnerships with early intervention and child welfare systems.

Strategy 7: Screen for and address maternal depression and other risks in health care settings serving women and young children.

Strategy 8: Implement parenting curricula and informal support groups designed for higher-risk families.

Strategy 9: Build a community approach to prevention and early intervention for groups of babies, toddlers, and families facing special risks.

Strategy 10: Include more vulnerable families in broader infant, toddler, and early childhood advocacy strategies.

Moving Forward

Even in the face of continuing budget cuts, high staff turnover rates, and often times greater demands on those who work directly with the most vulnerable babies and toddlers and their families, programs and communities have been able to:

- Develop effective outreach and engagement strategies to provide earlier interventions to those at greatest risk.
- Provide services at critical times of need, such as police involvement and domestic violence support services.
- Enhance collaboration across systems and service providers, such as child welfare services and early intervention services.
- Mobilize the needed range of skills and staff to address the range of family needs, such as drug and alcohol treatment, early childhood development services, early intervention, psychologists, health practitioners, and social workers.
- Provide mental health support and reflective supervision practices for staff working with the highest-risk families.

Important challenges both from a resource as well as a clinical perspective also face the field. These include the need to:

- Develop culturally appropriate and effective treatments for both parent and child depression and mental illness, particularly for immigrant and refugee families.
- Find and retain high-quality and appropriately skilled staff and provide resources to address staff depression and job stress among those working directly with infants and toddlers.
- Build "healthier" partnerships among child protective services, early intervention, mental health, substance abuse treatment, and domestic violence services in the context of the broader early childhood agenda.

- Promote a research agenda among local programs that includes not only outcome data, but also information on how well programs are actually implemented. Lessons from Early Head Start evaluations suggest that this is key to moving to a new level of program effectiveness.

Ten Principles to Guide Policy, Practice, and Advocacy

1) Start with the parents, but connect with the whole family—not just the mother and the young child—and don't forget the fathers, wherever they are.
2) Work in partnership with community leaders (promoters, mentors, resource moms, and others).
3) Target important moments and transitions in families' lives (such as pregnancy, birth, entrance into early childhood programs, probation/incarceration).
4) Connect with families as early as possible (starting during prenatal care is best).
5) Connect with families across as many settings as possible (such as churches, other faith-based organizations, informal child care providers, and resource and referral agencies).
6) Use multiple entry points for access to family-focused screening, assessment, prevention, and more intensive treatment (such as community health clinics, family court, juvenile justice system, substance abuse programs, and shelters).
7) Make sure that parenting programs are responsive to the special needs of more vulnerable families.
8) Nurture the staff. Make sure there are supports for child care staff that are depressed, stressed, and burnt out (such as access to early childhood mental health consultation).
9) Find ways to use existing funding more efficiently, and then seek new funding for specific purposes.[11]
10) Train the next generation of professionals with real families as their teachers, especially families who have overcome burdens. For example, assign medical and other graduate students for a year to a family with a new baby to understand the context of stressed families' daily lives, their celebrations, and hardships.

Conclusion

Each year, over 4 million young children are born, many of them into loving, nurturing homes regardless of family income. For those less fortunate, it is in the public interest to invest in interventions that can help change a negative development course to a positive one. The strategies highlighted in this document provide a framework with which to start. Helping the most vulnerable infants, toddlers, and parents is not easy, but if we fail to do so, the consequences will most surely spill over into the next generation.

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This issue brief focuses on the special challenges of helping babies and toddlers whose earliest experiences, environments, and especially relationships ... [expose] them to such high and consistent levels of stress that their growing brains cannot integrate their experiences in ways that promote growth and learning.

Introduction

Compelling evidence from neuroscience about how early relationships and experience influence the architecture of the brain,[1] and in turn early school success, has led to increasing policy and practice attention to infants and toddlers. Even as states, communities, and foundations are mobilizing to promote universal access to prekindergarten for 3-4 year olds, there are efforts to increase attention to promoting healthy development in infants and toddlers. (See: Promoting the Well-Being of Infants, Toddlers, and Their Families: Innovative Community and State Strategies, at: <www.nccp.org/it_index.html>.) Encouraged by positive research findings from Early Head Start (EHS), for example, a number of states are investing their own dollars in this or similar programs. (See Box 1.) At the same time, many states and communities are supporting research-informed home visiting programs, as well as a range of other programs targeted to promote healthy early relationships and prevent problems, particularly for low-income families. Communities are investing in common training across agencies for all who work directly with families of infants and toddlers. For many families, access to these programs provides just the kind of experience for both the moms and the babies, and sometimes the dads or grandparents, which is necessary to "jumpstart" healthy development.

But, there is also a group of babies, toddlers, and parents who face so many risks that programs like these alone may not be enough. This issue brief focuses on the special challenges of helping babies and toddlers whose earliest experiences, environments, and especially relationships create not a warm and nurturing atmosphere, but what scientists have called "toxic stress"—exposing them to such high and consistent levels of stress that their growing brains cannot integrate their experiences in ways that promote growth and learning.[2] It describes 10 strategies that programs and communities can implement to ensure these babies, toddlers, and families are connected to sufficiently intensive supports that can get them on a path to early school success. The issue brief builds on previous work carried out by the National Center for Children in Poverty,[3] and on a meeting that NCCP, in partnership with Zero to Three, the Better Baby Care Campaign, and Voices for America's Children, held in October 2004. That meeting brought together researchers, practitioners, policymakers, community leaders, and advocates to explore, through a policy and program lens, the challenges of serving more vulnerable infants, toddlers, and families, while at the same time working to expand access to supportive programs for all families with infants and toddlers. (See Appendix A for a list of participants.) For a fuller description of many of the specific programs mentioned in this document, see *Resources to Promote Social and Emotional Health and School Readiness in Young Children and Families—A Community Guide*, at: <www.nccp.org/pub_rps05.html>.

Box 1: Promoting Healthy Relationships and Preventing Problems

- *Early Head Start (EHS)* is a comprehensive community-based program for low-income families with infants and toddlers and pregnant women. EHS provides families with early education services, home visits, parent education and parent-child activities, health and mental health services, and high-quality child care services. It empowers families through parent education on child development, adult education, literacy skills, job skills training, and assistance with other services such as housing, income support, and transportation. Rigorous research on Early Head Start shows positive effects on most children and families who participate.*
- *Educare* was started in Chicago, Illinois by the Ounce of Prevention Fund and is a research-based model that builds on what works: starting early, providing intensive services, being comprehensive, ensuring quality, and focusing on relationships. It provides full-day, full-year, high-quality center-based care, education, and family support for children birth to age 5 and their families. The emphasis is on creating nurturing relationships between staff and children, between staff and parents, and among parents (often teen parents). The program pays special attention to providing continuity of care and helping children and families deal with transitions. The program also works with pregnant families, especially teen moms, before birth, using especially trained home visitors called doulas. In a recent evaluation,** Educare children performed as well as other urban African-American children attending Head Start programs in literacy skills; by the end of the program year, the 3-5 year olds exceeded the developmental range for their age on a literacy screening instrument. Educare also provides training and support to Educare programs that are starting up in other cities as part of public/private partnerships.
- Touchpoints™ is a training approach/philosophy and curriculum targeted to child care and health providers to teach them specific strategies and a common language for working with families with infants and toddlers, especially low-income and/or stressed parents. It is designed to be integrated into a wide range of programs and community strategies to help build a shared set of expectations and approaches to parents with babies.

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* Love, J. M.; Kisker, E. E.; Ross, C. M.; Schochet, P. Z.; Brooks-Gunn, J.; Paulsell, D.; Boller, K.; Constantine, J.; Vogel, C.; Fuligni, A. S.; & Brady-Smith, C. (2002). *Making a difference in the lives of infants and toddlers and their families: The impacts of Early Head Start, Vol. I: Final Technical Report.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Evaluation, Child Outcomes Research and Evaluation and Administration on Children, Youth and Families, Head Start Bureau. Prepared by Mathematica Policy Research under Contract DHHS-105-95-1936.

** Yarbrough, K. (2005). *The first days of life: Adding doulas to early childhood programs.* Chicago, IL: Ounce of Prevention Fund <www.ounceofprevention.org/downloads/publications/First_Days_of_Life.pdf>.

Parents of vulnerable babies and toddlers are themselves in highly stressed economic and psychological circumstances—facing risks above and beyond poverty and low educational levels that include domestic violence, maternal depression and/or addiction, and homelessness, singly, or in combination.

Setting the Context

Research and experience suggest that there are two groups of young children who are most vulnerable to developmental and emotional difficulties related early school failure. The first group, and by far the largest, is composed of infants and toddlers (and preschoolers) whose earliest experiences fail to provide them with even the minimum levels of nurturing parenting care and stimulation. The second group is made up of infants and toddlers (and preschoolers) with health or developmentally related delays and or emotional and behavioral disorders even in the face of nurturing parenting and stimulation. Many of these parents report that from the beginning, they knew there was something wrong with their children, and often, no one would listen. Disproportionately, both groups of young children are found in low-income, often extremely low-income, families.

These young children get off to a developmentally rocky start that puts them on a negative developmental path. Often, as babies, they are described as showing serious problems in their ability to relate to others or regulate their own emotions; as preschoolers they "misread" the cues of others or disconnect from learning. Some are angry and aggressive; others are withdrawn and unable to communicate. Some are both. Typically, and euphemistically, they are described as children with the most "challenging behaviors." Many, even though very young, have witnessed or experienced traumatic events. Sometimes, their parents are unable to protect them from actual or psychological harm; for a small group of them, parents or other relatives may inflict the harm.

Most importantly, many parents of vulnerable babies and toddlers are themselves in highly stressed economic and psychological circumstances—facing risks above and beyond poverty and low educational levels that include domestic violence, maternal depression and/or addiction, and homelessness, singly, or in combination. And these parents have themselves often had long histories of trauma and/or the experience of poor parenting—information not often acknowledged in either research or interventions. Although these facts have enormous implications for structuring effective interventions, they are mostly ignored in our current service and policy frameworks, virtually assuring that the consequences will spill over into the next generation.

Defining Vulnerability: Empirically-based Approaches

Babies and toddlers who, in the aggregate, face the most severe threats to their healthy development are disproportionately in families with some combination of demographic, family, and environmental risk factors. A few basic facts about these families provides the context for their children's vulnerability. The current poverty level for a family of three is about $16,000. Of the 11 million infants and toddlers, some 43 percent live in low-income families—in families with incomes at or less than 200 percent of the poverty level, and 21 percent are in families with incomes at or below the poverty level. Nine percent of all infants and toddlers live in dire poverty, in families with incomes that are half or less of the poverty level. About 26 percent of all infants and toddlers in low-income families (1.2 million) live with parents who have less than a high school education. Disproportionately, these children are also living in families of color. (For more information about young children in low-income families, see NCCP's *Basic Facts About Low-Income Children: Birth to Age Three* at <www.nccp.org>.)

Given the challenge of using scarce resources for these infants and toddlers in the most effective way, it is important to define the parameters for vulnerability with even more specificity. Currently, there are three approaches to identifying levels of risk in young children, all based in some way on empirical and theoretical developmental science and especially the overwhelmingly consistent finding from resilience research that the more risk factors, the worse are the odds for healthy child development.

Risk Indices

One approach to defining vulnerability is to develop risk indices. In theory, these indices could reflect some combination of demographic, child, family, and environmental risks, and impacts could be studied systematically. In fact, existing indices largely use just demographic factors, but even they alone are predictive. For example, Early Head Start researchers used a risk index that included being a single parent, receiving public assistance, being neither employed nor in school or job training, being a teenage parent, and lacking a high school diploma or GED. Twenty-six percent of the families enrolled in Early Head Start experienced four or more of these risk factors. That sub-sample of Early Head Start families did not benefit from the program in the same way that other families did.[4]

Circumstantial Risk

A second approach is to simply identify young children in circumstances known to place them at risk by virtue of their exposure to ineffective parenting or parental absence. These include:

- The more than 150,000 young children under age 6 in foster care in 2003, including 25,000 infants. Most have experienced or are at risk for major disruptions in attachment.[5]
- Over 300,000 young children with incarcerated parents (half of whom are infants and toddlers). Just over one in five children of prisoners, including men and women, are under age 6.[6]
- An estimated 550,000 young children in homeless families.[7] (There are no separate figures for infants and toddlers.)

- The just over 175,000 infants and toddlers who were victims of substantiated abuse and neglect in 2003, representing 22 percent of all child victims. (Infants and toddlers have the highest rate of victim investigations—16.4 per 1,000—and are most likely to suffer a recurrence.)[8]

These numbers represent a rough guide. However, there are three caveats: 1) These are not unduplicated counts; young children who experience any one of these circumstances, often experience more than one. 2) Not all young children in these circumstances will in fact experience compromised development. Some, although research suggests only a small group, will be resilient, and will develop appropriately even under the most challenging circumstances. 3) These figures do not really capture the level of risk that the young children experience. For example, even for young children whose families are not available, a caring, consistent relationship with at least one adult may protect a child against future problems. An infant or toddler in a family made homeless by a dramatically increased rent faces very different risks from a young child in a family where the mother is homeless because she has found the courage to leave an abusive partner after three years of chaos and fear, or where the child has also been abused.

Prevalence-based Risks to Effective Parenting

A third approach is to use prevalence data based on parental risk factors known to impair effective parenting. This is a particularly important and underutilized approach, especially for infants and toddlers. Impaired parenting—often defined as harsh, inconsistent, or indifferent parenting—is known to be related to poor developmental and emotional outcomes in young children.[9] Factors that place young children at serious risk for such parenting include maternal depression, substance abuse, domestic violence, and—although we lack even estimates of national prevalence rates—the parents' own unaddressed childhood or current trauma. (See Box 2.)

Taking a prevalence perspective:

- An estimated 10 percent of all young children live with parental substance abuse/dependence.[10]
- An estimated 1.4 million to 4.2 million young children experience domestic violence.[11]
- A large number of young children have parents with either clinically diagnosed or clinically significant symptoms of depression, often with other risks as well.

For example, in a recent study of Early Head Start parents, a stunning 47 percent of the parents had depressive symptoms.[12] In a study of 220 homeless mothers with young children, 92 percent had experienced severe physical and/or sexual assaults at some point in their lives, more than 40 percent had a major depressive disorder, and more than 33 percent have experienced Post Traumatic Stress Disorder.[13] In a study of low-income women in family planning clinics, 24 percent reported a history of rape, 22 percent had been sexually molested, 33 percent had been victims of physical attack, 20 percent had a history of physical abuse. Comparable rates for women in the general population are: 9 percent, 12 percent, 7 percent, and 5 percent.[14]

Box 2: Parental and Caregiver Depression and Infants and Toddlers: Selected Short and Longer-term Findings

- Maternal depression affects a child's later cortisol levels. Elevated cortisol levels have been linked with internalizing problems, extreme behavioral inhibition, social wariness and withdrawal, as well as increased anxiety disorders. Children who were exposed to significant maternal depression at age 1, 4, and 12 months, and then at 4½ years of age were found to be at increased risk for mental health problems at the end of first grade.[1]
- Maternal and paternal depression among Early Head Start parents was associated with poorer child functioning and increased aggressive behavior in the children, as well as increased negative parenting behavior, parenting stress, and family conflict.[2]
- Mothers who are stressed and depressed talk less to their children, and their children have more limited vocabularies.[3]
- Children whose mothers had been depressed in the months after childbirth had more symptoms of attention-deficit disorder/hyperactivity and problems with anger management at age 11 years than other children.[4] For children whose mothers had been depressed at age 3 months, the symptoms were the most severe.
- United Kingdom preschool-aged children whose fathers were depressed during the postnatal period were at increased risk of behavioral problems (conduct, emotional, hyperactive) at 3½ years of age, especially for boys.[5]
- Mothers with depression are less likely to engage in child preventive health practices (such as regular vaccinations; use of child seat belts, refraining from smoking, and child proofing the house) and less likely to complete well-child visits.[6]
- Nonfamily child care providers of children ages 15 months, 24 months, and 36 months with self-reported depressive symptoms were less sensitive, had higher ratings of withdrawal, and interacted less frequently with the children in their care.[7]

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Research tells us that the consequences of these parental risks for young children include lowered I.Q. and cognitive development; failure to master age-appropriate developmental tasks in early childhood, increasing evidence of maladaptive social and emotional functioning in childhood and high-risk behaviors in adolescence,[15] risk transmitted to the next generation,[16] and high levels of mental health problems as adults.[17] And yet, addressing parental barriers to effective parenting has not been used as a systematic component of interventions targeted to more vulnerable families.

It should also be noted that there is a fourth, nonempirically based approach. That approach uses the garden variety list of risks (abuse, maltreatment, or neglect; exposure to violence; homelessness; removal from child care, Head Start, or preschool for behavioral reasons or at risk of being removed; exposure to parental depression or other mental illness; family income below 200 percent of the federal poverty level (FPL); exposure to parental substance abuse;

early behavioral and peer relationship problems; low birth weight; or cognitive deficit or developmental disability[18]) and hinges eligibility and access to programs/services to some number of risk factors. For example, the 8 states that include infants and toddlers at risk for developmental delay in their federal Early Intervention program (Part C of the Individuals with Disabilities Education Act—IDEA) largely use this approach, as does the small grant-funded program Foundations for Learning that is part of the No Child Left Behind Act enacted in 2002.

The Research Rationale for Paying Special Attention to the More Vulnerable Infants, Toddler, and Families

Three clusters of research form the foundation for investing in more intensive, family-focused early intervention. Below, briefly, we summarize the take home messages and discuss the implications of the research for services and policies to help more vulnerable infants, toddlers, and families.

First, and in some ways the most dramatic, are the emerging lessons from early brain research.[19] Never before have we known so much about how young children's brains develop and why it is important to invest in efforts to make sure that the earliest experiences of young children, and especially babies, are positive. Over the past decade, neuroscientists studying early brain development have uncovered the complex process by which a baby's genetic endowment (what one scientist has called a genetic library) is shaped by the quality of the relationships and stimulation the baby experiences that in turn shapes how the brain develops. The newborn brain develops at an astonishing speed during the first few years of life, transformed by the child's temperament and other biological characteristics in the context of the child's relationships with adult caretakers. These relationships constitute a basic building block for the child's development.

The same research makes clear that while for most young children, infancy is a time of great developmental opportunity, it can also be a time of great vulnerability if the environment does not provide the basic level of nurturing and stimulation that the early brain needs.[20] Scientists are beginning to study what happens to babies who experience what they are calling "toxic stress"—stress that overwhelms the baby's developing brain. Under these circumstances, the brain gives off chemicals that inhibit the ability to regulate emotions and to learn in age-appropriate ways. It also seems to change, in some fundamental way, the response to stress, reducing the capacity of children to be in a nonstressed state. It is as if these children cannot "turn off" the stress response. In the most extreme circumstances, toxic stress actually stifles brain growth.[21]

Some research is also beginning to show that secure attachment can literally block the hormonal response to stress. Strong secure attachments to caregivers can buffer or prevent elevations of stress hormones in situations that usually elicit some distress in infants.[22] And, importantly, preliminary brain research using animals tells us that early damage can be reversed, especially when young children are provided with appropriate nurturing.[23] Thus, early brain research points to the importance of prevention as well as early intervention in particularly powerful ways.

While for most young children, infancy is a time of great developmental opportunity, it can also be a time of great vulnerability if the environment does not provide the basic level of nurturing and stimulation that the early brain needs.

The second cluster of research that forms the cornerstone for investing in more vulnerable young children is the large body of research on risk, resilience, and protective factors that has emerged over the past decades. This research reinforces the importance of relationships to healthy development. Paralleling the findings from brain research, resilience researchers report that effective parenting (whether carried out by parents or others in primary care roles) that provides both nurturing and monitoring is the single most robust protective factor for children exposed to various adversities.[24]

Risk and resilience research also tells us that, often, the specific risk factors that are present are less important than the numbers of risks. One of the most consistent messages from research is that the more risk factors there are, the more likely both parents and children will experience material and emotional hardship and the children will have poor outcomes.

Beyond that, the research has also helped identify a set of both risk and protective factors that repeatedly emerge as predictive of either negative or positive outcomes. Among the former, for example, cumulative research leaves no doubt that harsh, inconsistent, or indifferent parenting places young children in harm's way developmentally. But research has also implicated community factors such as community violence. Protective factors that buffer children from poor social, emotional, and behavioral outcomes include forces external to the child, such as positive relationships with a caring adult and informal support systems, relationships with peers or schools for older children, as well as the child's own attributes.

In a version of tipping point theory, this body of research has also shed light on how the balance between risk and protective factors shape social, emotional, behavioral, and cognitive outcomes for children. We have learned that even in the face of significant adversity, some children, by virtue of their own temperament, are resilient and seem to thrive, although recent research suggests that even when some of these children appear to be doing well, as adolescents, they may show great internal distress. For example, children of alcoholics who as preschoolers showed low behavioral deviance continued to show low behavioral deviance as adolescents, but had internalizing symptoms as high as the most troubled group studied.[25]

Appropriate Goals for Interventions Targeted to the More Vulnerable Infants, Toddlers, and Families

Most parents, including those facing many risks, want their babies to succeed, and they want to be good parents. But parents facing more risks typically do not have the tools to cope. The usual parent training and family support approaches are unlikely to be robust enough to override their own poor parenting experiences. Further, both research and experience suggest that interventions should include treatment for parental risks as well as efforts to strengthen parenting and parent-child interactions.[26] Interventions that are designed to address the often complex and multiple needs of higher-risk families with infants and toddlers vary in approach and entry points. Some involve more formal treatment; others focus on building a support network for isolated families. In general, research supports an integrated four-pronged approach:

- **Promote healthy, effective parenting responsive to complex parental risks.** This means helping the parent as a parent in the context of real parent-infant interaction (such as promoting practice in how to read a baby's special language; what is age-appropriate behavior; how to relate to babies; how to parent while in recovery[27] or depressed[28]).
- **Provide interventions that explicitly address parental risk factors.** This means helping the parent get needed assessment and intervention/treatment to reduce or treat risks such as depression or unaddressed trauma, to the extent possible in the context of normal early childhood and parenting support programs and strategies.
- **Connect babies and toddlers with necessary health and related services.** Babies in high-risk circumstances may not be connected to medical homes (defined as primary care services that are accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective[29]) or referred to early intervention services. Effective interventions ensure that babies and toddlers have a regular medical office to visit for well-baby checkups and emergency care, health insurance, up-to date immunizations, and screenings for developmental delays and social and emotional development.
- **Address the concrete needs of the family.** This means problem solving with the parents to relieve the ongoing hardships and chronic crises so many of these families face and to ensure that the families are connected to government benefit programs and other resources such as food pantries.

Even in the most high-risk families, unless a child's safety is at stake, the best way to promote healthy development and reduce risks is to help the baby's parents and other caregivers. To do this, both practice experience and research based on carefully designed studies suggest that duration, intensity, flexibility, the ability to address multiple needs of families, and above all, the ability to forge a collaborative partnership with the primary caregiver, no matter what the parental limitations, all seem to be necessary.[30]

These principles are reflected in the 10 strategies highlighted below. Together the strategies represent a framework for intentional program, community, and state action on behalf of the most vulnerable infants and toddlers, their families, and their other caregivers.

Research suggests that the most powerful single policy action to improve outcomes for low-income infants and toddlers would be to support, nationally or within states, the expansion of Early Head Start (EHS) or similar programs.

Ten Strategies to Help Infants, Toddlers, and Families at Higher Risk for Poor Outcomes

Strategy 1: Ensure that ALL low-income families have access to infant and toddler child development and family support programs.

Having high-quality infant and toddler development and family support programs available in every community is fundamental to helping higher-risk families. Ideally, such programs should be universally available, but given resource limits, at least ensuring access for all infants and toddlers in poverty whose families wish to participate and then all low-income families in need is key. Research suggests that the most powerful single policy action to improve outcomes for low-income infants and toddlers would be to support, nationally or within states, the expansion of Early Head Start (EHS) or similar programs. Rigorous research on Early Head Start shows patterns of positive findings for both parents and babies. But the findings also concretely illustrate the importance of including families facing risk factors in core comprehensive child development and family support programs. EHS research showed that although EHS did not impact depression itself, it did impact both parenting and child outcomes. Depressed mothers were more positive and less negative in interactions with their children, and their children were more engaged, more attentive, less aggressive, and had more positive parent-child interactions than their peers who did not attend EHS. Furthermore, EHS parents were less likely to use harsh discipline strategies and had a wider array of positive strategies to cope with parent-child conflict.[31]

Strategy 2: Embed research-informed intensive interventions into Early Head Start and home visiting infant and toddler child development and family support programs.

Over the past decade, there have been major developments in infant and parent family therapies.[32] Using this knowledge base not just in clinical settings, but embedding more intensive interventions into core infant and toddler child development and family support programs appears to be one of the most promising strategies in which states and communities might invest. Families are more willing to accept help in settings they trust. Further, serving higher-risk families in the context of on going, strength and relationship-based programs for all infants and toddlers is a "twofer." Families who often experience stigma or isolation can be supported in a normalizing context, and there is ongoing basic reinforcement for and modeling of healthy relationships. Below, we highlight three examples of how these more intensive

strategies, or to use an Early Head Start term "enhanced" services, can be embedded into ongoing programs.

Early Head Start Programs as Platforms for Serving Families at High Risk

- In Syracuse, New York, **People's Equal Action and Community Effort, Inc. (P.E.A.C.E., Inc.)**, an Early Head Start program, has three different programs for families facing special risks. For mothers facing depression, P.E.A.C.E. is testing the Reducing Depressive Symptoms in Low-Income Mothers project, a 5-month in-home intervention for mothers in Early Head Start who have significant depressive symptoms. For mothers dealing with substance abuse, P.E.A.C.E. is partnering with the Crouse Memorial Hospital Chemical Dependency Treatment Program, which provides comprehensive programming to eight pregnant/post partum women substance abusers and their children from birth to age 3. The mothers enrolled in the treatment program receive their services 3 mornings per week, while their children receive child care services provided by Early Head Start at the treatment site. P.E.A.C.E. also partners with the Onondaga County Correctional Facility to serve a small number of pregnant and postpartum women who are provided with two family advocate workers, a transitional visitor, a coordinator of special projects, and a male involvement specialist. The program collaborates with the staff to ensure the continuity of services for the women and children during incarceration and after release.
- In Boston, Massachusetts, through the **Family Connections Project**, the Action for Boston Community Development (ABCD) Early Head Start program has formed a community and research partnership with the Dimock Community Health Center, Associated Early Care and Education, and Harvard Graduate School of Education, to address the needs of Early Head Start/Head Start families struggling with the debilitating effects of parental depression. The program provides training and consultation for staff to help these parents build the necessary skills for engaging with their children. In addition, the program sponsors psychoeducational groups that offer information and skill development support for parents, classroom consultation, and special on-site interventions to promote children's social competence and healthy interactions. Home visitation, outreach to more vulnerable parents, and community resource networking and referral services are also provided.

Home Visiting Programs as Platforms for Serving Families at Higher Risk

Many states and communities invest a significant proportion of their resources allocated to infants and toddlers in home visiting programs, but these programs struggle with how best to serve more vulnerable families. Like Early Head Start, some programs are beginning to embed parent treatment strategies into their core programs.

- **Every Child Succeeds (ECS)** is a cross-regional home visiting prevention program using two models, Healthy Families America and the Nurse Family Partnership, and serving demographically at risk first time mothers and their children. Research on program participants found that 44 percent of the mothers exhibited elevated levels of depression in the first year of service and interpersonal trauma was common; 69 percent of mothers were victims of abuse or violence. In response, partnering with researchers at Cincinnati Hospital, ECS integrated In-Home Cognitive Behavior Therapy (IH-CBT) into the program.

IH-CBT was chosen because it can help parents begin to see themselves, their babies, and their relationship with their babies in a more positive light. After 17 treatment sessions. 70 percent of the depressed mothers no longer met criteria for major depression; an additional 15 percent exhibited partial recovery. Mothers reported substantial decreases in depressive symptoms and greater acceptance of and a closer bond with their children. Most importantly, help to the moms seemed to get the babies back on an age-appropriate developmental track.[33]

Strategy 3: Embed intensive interventions for infants and toddlers and their families in settings serving only high-risk families.

Ironically, many of the families with infants and toddlers facing the greatest risks are not actually enrolled in child development and family support programs. They are more likely to come into contact with the formal service systems through specialized entry points, such as shelters for homeless families or families experiencing domestic violence, the courts, or child welfare offices. Therefore, it is critical that these settings be seen as entry points for community services and supports for more vulnerable infants, toddlers, and families. Below, we highlight programs that use homeless shelters, the courts, or hospitals as entry points.

- In San Francisco, California, the **Homeless Children's Network (HCN)** aims to decrease the trauma of homelessness and domestic violence and to provide early childhood education and consultation to shelter-based child care and family child care providers. A collaboration of 19 emergency, transitional, and domestic violence shelters provide a wide range of services, including: family counseling to increase communication skills, play and talk therapy to give abused children an opportunity to work through their traumas and reduce the risk of recycling abusive behaviors; parenting groups to raise parent confidence and competence in parenting skills; and consultants to child care centers where the children are enrolled.
- In Miami, Florida, the court has become the focus for a number of initiatives to improve outcomes for infants and young children, including Florida's **Infant and Young Children's Mental Health Pilot Project (IMHPP)** and Miami Dade Juvenile Court's **Miami Safe Start Initiative**. Under the leadership of the Honorable Judge Cindy Lederman, the Miami

Box 3: Research Findings from Court Initiatives for Infants and Toddlers in Miami-Dade County

- Over half of the maltreated infants, toddlers, and preschoolers assessed by the Court experience significant cognitive and language delays placing them at serious risk for learning problems
- Three years of data from the dyadic therapy show substantial gains in improving parental sensitivity, child and parent interaction, and behavioral and emotional parent and child responsiveness and affect.
- Children who received the dyadic therapy showed significant improvements in enthusiasm, persistence, and other positive behaviors, and a reduction of depression, anger, withdrawal, and irritability.
- There have been no further acts of abuse or neglect, and the reunification rate is an extraordinary 86 percent in the Miami dyads.

Source: Adams, S.; Osofsky, J.; Hammer, J. H.; & Graham, M. (2003). *Program evaluation: Florida Infant & Young Child Mental Health Pilot Project, year 3, final report: July 1, 2000 to June 25, 2003*. Tallahassee, FL: Florida State University Center for Prevention & Early Intervention Policy, submitted to Florida Department of Children & Families, Children's Mental Health <www.cpeip.fsu.edu/resourceFiles/resourceFile_20.pdf>. For further information see: <www.miamisafestart.org>.

Dade Juvenile Court was the first juvenile court to conduct developmental assessments of infants, toddlers and preschoolers. The Court also initiated the Infant Mental Health Pilot Project, providing dyadic therapy to infants and caregivers most likely to benefit. The results, even with a small sample, have been impressive (see Box 3). In addition, using funds from the Miami Safe Start Initiative, there is now a court-linked Early Head Start program for maltreated infants and toddlers to increase community capacity to provide intervention services to young children who are victims of, or who are exposed to violence in their homes and/or communities. The toddlers who are enrolled in the comprehensive EHS program also receive dyadic therapy with their primary caregiver, provided by the University of Miami's Linda Ray Intervention Center. The IMHPP receives state funding; Miami Safe Start receives funding from the Eleventh Judicial Circuit in Miami and from the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

- In New York, **Babies Can't Wait**,[34] developed under the leadership of the New York State Permanent Judicial Commission on Justice for Children, is working to increase the well-being and permanency of infants in foster care. Through a combination of cross-system collaborations, trainings, and an infant healthy development checklist (see Box 4) staff from the Bronx Family Court, the child welfare system, CASA (Court Appointed Special

Box 4: Excerpts from the Infant and Toddler Healthy Development Checklist

What are the medical needs of this infant?

- What health problems and risks are identified in the infant's birth and medical records (for example, low birth weight, prematurity, prenatal exposure to toxic substances)?
- Does the infant have a medical home? Are the infant's immunizations complete and up-to-date?

What are the developmental needs of this infant?

- What are the infant's risks for developmental delay or disability?
- Has the infant demonstrated attachment to a caregiver?
- Has concurrent planning been initiated?
- What are the attachment needs of this infant?
- Has the infant had a mental health assessment?
- Does the infant exhibit any red flags (for example, chronic sleep or feeding disturbances, excessive fussiness, multiple foster placements) for emotional health problems?
- Has the infant been referred to the Early Intervention Program?

What challenges does this caregiver face that could impact his or her capacity to parent this infant?

- What are the specific challenges faced by the caregiver in caring for this infant (for example, addiction to drugs and/or alcohol, mental illness, cognitive limitations)?
- What are the learning requirements for caregivers to meet the infant's needs?
- What are specific illustrations of this caregiver's ability to meet the infant's needs?

What resources are available to enhance this infant's healthy development and prospects for permanency?

- Does the infant have Medicaid or other health insurance?
- Is the infant receiving services under the Early Intervention Program?
- Have the infant and caregiver been referred to Early Head Start or another quality early childhood program?

Source: A Checklist for the Healthy Development of Infants in Foster Care, in Dicker, S. & Gordan, E. (2004). *Ensuring the healthy development of infants in foster care: A guide for judges, advocates, and child welfare professionals.* Washington, DC: Zero to Three.

Advocates), attorneys, child development professionals, and others are learning to better identify and address the health care needs of infants, understand and support caregivers' capacity to meet them, enhance babies' prospects for permanency, and link babies in foster care to medical care, Early Intervention, and early childhood services. Systematically using the checklist has already had positive results: in one analysis, every infant had up-to-date immunizations, and nearly 80 percent of the infants had an assigned pediatrician, a next visit scheduled, and a referral to an EI program when needed.

Strategy 4: Organize services by level of family risk.

Research is very clear that the more risk factors young children experience, the more likely they are to have social and emotional problems and exhibit challenging behaviors. This suggests the importance of organizing services by the level of risk the family experiences. Some groups of families need minimal interventions, while others need more intensive supports.

- **San Mateo Prenatal to Three Initiative (Pre to 3)** Through a collaboration of public and private agencies, the San Mateo Prenatal to Three Initiative targets all pregnant women and newborns covered by Medi-Cal and any high-risk children up to age 5. Families are assigned to one of three home visiting teams. One team works with the pregnant and parenting women with low to moderate risk, providing a limited number of visits. The second team works with families experiencing violence and mental health issues; and the third team is for families facing risks related to substance abuse. Nutritionists, infant development specialists, and community-based paraprofessionals offer additional support to families seen by the public health nurses and social workers who lead the teams. To complement this strategy, all staff who work with Pre to 3 families are trained in Touchpoints™—a training approach/philosophy and curriculum targeted to child care and health providers to teach them specific strategies and a common language, across a program or a community, for working with families with infants and toddlers, especially low-income and/or stressed parents. Parents also have access to drop-in parent support centers. In addition, all young children are screened for health and developmental risks using the Ages and Stages questionnaire, with a follow-up referral as needed.

Strategy 5: Use basic support programs for families to provide more intensive services.

Core basic federally funded support programs, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Temporary Assistance for Needy Families—TANF, also represent potential entry points for screening and providing additional supports to higher-risk families with infants and toddlers.

- **Coordinated Rewards Illinois Babies (CRIB)** joined together WIC and the Illinois' Family Case Management (FCM) program to target pregnant women and infants from low-income families and reduce rates of low birth weight and infant mortality. CRIB was a complete integration of two programs that traditionally functioned in isolation from each other, even when both programs were provided by the same agency to the same clients. The structure of CRIB was based on client need; pregnant and postpartum women received nutritional

The more risk factors young children experience, the more likely they are to have social and emotional problems and exhibit challenging behaviors.

assistance, prenatal care, family planning assistance, income support, health insurance, and a host of other services dictated by their individual circumstances. All services provided could be obtained by working with one staff person, during one appointment, while enrolling in either program. Clients entering the welfare/family support system at any point could be directed to services as varied as childhood immunizations, EI, pediatric primary care, breast and cervical cancer screenings, diabetes control, and referrals for mental health, substance abuse, domestic violence services, child care, or job training. Although CRIB is no longer funded, the elements of CRIB are still integrated into the WIC program in Illinois.

Strategy 6: Build partnerships with early intervention and child welfare systems.

Recognizing the urgency of ensuring that the youngest children entering the child welfare system or exposed to abuse and neglect have access to appropriate interventions (for example, as noted earlier, half the young children referred to the Court in Florida's Miami Dade County had developmental delays), Congress recently enacted legislation requiring that infants and toddlers with substantiated child abuse or neglect reports be referred to the local early intervention system for assessment, and if necessary, developmental services. In addition, Early Head Start programs are partnering with other agencies.

- Through a **Federal Early Head Start Child Welfare Demonstration Initiative**, Early Head Start programs have formed partnerships with child welfare agencies (and in one instance, a residential treatment program for substance-abusing women) to improve the capacity of Early Head Start to support infants and toddlers in or at risk for child welfare placement. Children served are born drug addicted or drug impacted or are suffering in other ways from child abuse or neglect. These babies and their families receive comprehensive child and family development services, including assessment, therapy, nutrition, and health services, and home visitation, although the specific approach varies from program to program.
- The **Massachusetts Early Childhood Linkage Initiative** (**MECLI**) links the Massachusetts Department of Social Services (DSS) to the Massachusetts Early Intervention System to ensure that families, kinship caretakers, and foster parents caring for children under age 3 who are involved in newly opened child abuse and neglect cases are routinely offered referrals to EI programs. The EI programs then assess the developmental status and provide services as needed. Implemented in three pilot sites, DSS has reported that two-thirds of families have been offered referrals and two-thirds have accepted the referral; about three-quarters of those evaluated were eligible for EI services. Fifty-two percent of evaluated children had developmental delays including: language (41%), adaptive/self-help (25%), gross motor (24%), fine motor (23%), cognitive (21%), and social-emotional (16%). (On average, a child with a delay had delays in three different domains.) Preliminary data shows that children who have been referred get fewer hours of services and cost less to serve than children with no indication of involvement with child protective services.[35]

Strategy 7: Screen for and address maternal depression and other risks in health care settings serving women and young children.

Because of the consequences for the healthy development of young children, it is important to identify serious risk factors in pregnant and parenting women and connect the women with the appropriate level of intervention as quickly as possible. Reliable screening tools can be easily administered in a wide variety of settings, including women's health clinics, clinics for pregnant and parenting women, and pediatric clinics.[36] Such screening recognizes that ensuring the healthy development of infants and toddlers, especially those in higher-risk family circumstances, is a "two-generational" challenge. It is critical to ensure that support services are available for families who screen positive for serious risk factors, including referrals to Early Head Start for the children as well as treatment for children and parents.

- **Chicago Health Resources and Services Administration Perinatal Depression Project** In Chicago, under the leadership of the Department of Public Health, the Perinatal Depression Project has involved a widespread effort to train providers who work with pregnant women to increase understanding, awareness, screening, assessment, treatment, and referral for pregnant and postpartum women at risk for suffering from depression. To date, over 1,000 providers have attended workshops and shorter presentation trainings to learn about how to recognize, screen, assess, and refer for perinatal depression; a demonstration site implementing a comprehensive system of screening, assessment, treatment, and referral has been developed at one health center; a toll-free perinatal depression consultation line is available, and a MotherCare Fair was held to alert the public. There are future plans for a Peripartum Depression Management Program as well.

Strategy 8: Implement parenting curricula and informal support groups designed for higher-risk families.

For young children and families facing multiple risks, the typical parenting curricula and support are not sufficiently relevant to engage the families or promote changed attitudes and behaviors. Research suggests that for these parents, effective parenting training and support strategies involve opportunities to reflect on their own parenting experiences, identify and practice new responses, experience support from others, and develop new understandings of child development. Communities can also harness the power of natural helpers and healers in the community, linking families sharing risks into an informal network.

Given the isolation of the most vulnerable parents of infants and toddlers, it is especially important for communities to harness the power of informal support groups, where parents experiencing similar risks can come together to support each other—particularly parents with new babies. Often these groups are cofacilitated by a parent in recovery, sometimes with, sometimes without a mental health or other facilitator.

Examples of curricula that have been or are being evaluated with higher-risk parents include:

- **Incredible Years Parent Training Component** (there are also teacher training and child-focused components) has been found to be effective with parents facing special risks (such

For young children and families facing multiple risks ... effective parenting training and support strategies involve opportunities to reflect on their own parenting experiences, identify and practice new responses, experience support from others, and develop new understandings of child development.

as involvement in foster care or depression). The Incredible Years has an impressive track record of success with parents who experience their own risk factors as well as positive impacts on children's behaviors.[37]

- **The Nurturing Father's Program**, a 13-week program for groups of eight to 16 men combines counseling, a structured curriculum, and tools and activities to understand feelings, communication, positive discipline, managing anger, and dealing with sons and daughters. One study included 300 fathers with children from birth to age 5. In informal surveys, of the 78 percent who completed the program, 83 percent showed substantial improvement as measured by an index of five parenting risk behaviors.[38] A similar approach is being piloted for families in substance abuse and treatment recovery. This curriculum has been implemented primarily with women with children from birth through age 5. Parents learn from peer-to-peer discussions, games and art, and other activities. Preliminary data are promising and show increased understandings of parent-child roles and empathy for children.[39]

Examples of informal support strategies include:

- **Raising Our Children's Kids (R.O.C.K.)** is a support group for grandparents and other relatives raising children. It provides peer-to-peer support, counseling, and interactions, crisis assistance, referrals to other social services and support programs, and access to a small library of resources to decrease feelings of isolation by identifying with others who are having similar experiences. Started by a local community mental health center, R.O.C.K. aims to provide caregivers with fun educational activities (including field trips), a place to vent and socialize with other grandparents/caregivers, open discussions, assistance with access to needed resources (such as respite care and school supplies), and local community guest speakers.
- **Sister Circles** In a number of cities around the country, groups of low-income women, especially African-American women, are coming together to support each other as they cope with challenging issues. A number of the Sister Circles involve women coping with depression. The group is both a support group and a social network.[40]

Strategy 9: Build a community approach to prevention and early intervention for groups of babies, toddlers, and families facing special risks.

Many of the serious risk factors that affect infants, toddlers, and families are linked to community as well as individual family risk factors; community norms, for example that do not challenge family violence, widespread drug dealing, or high levels of child abuse. Below, we highlight an example of a community planning and action strategy that looks across risk factors facing young children.

- The **Pima County Prevention Partnership** in Tucson, Arizona aims to prevent future delinquency and conduct disorder in young children at special risk through community partnership and planning, training, screenings, and support services. Drawing on research linking early risks to later delinquency and conduct disorders, Pima County identified four different populations at highest risk: 1) young children exposed to violence in the home; 2) dually adjudicated children (child welfare and juvenile delinquency); 3) aggressive preschoolers; and 4) children with incarcerated parents. In response, the county developed a strategic plan that it is implementing as resources permit. For young children, to date, Pima County has implemented: training for police officers when making arrests or called to homes to ask if there are children, where are they, and how old they are; mandated behavioral screenings for young children exposed to child trauma (such as arrest of a parent or domestic violence), and created Second Step, a social skills curriculum for use in early education programs.

Strategy 10: Include more vulnerable families in broader infant, toddler, and early childhood advocacy strategies.

Despite the compelling scientific evidence for increased and more strategic investments in the earliest years, making the advocacy case continues to be difficult. Even the most widely researched and evidence-based program, Early Head Start, only serves 62,000 of the 4.7 million low-income babies and toddlers who are eligible. The gap between what we know and what communities and states are able to do for babies and toddlers is deep and wide. Strong advocacy on behalf of infants and toddlers within the context of the broader early childhood agenda is crucial.

- The **Better Baby Care Campaign** is a national initiative to encourage and support state and local communities to promote the healthy development of babies, toddlers, and their families spearheaded by Zero to Three and Voices for America's Children. Targeted to states, tribes, and local communities, the campaign is a comprehensive, research-based effort to inform public policy, build public will, advance professional education, and enhance practice so that all babies and toddlers will have good health, strong families, and positive early learning experiences. Zero to Three currently provides pass-through funding to Better Baby Care grantees in nine states: Delaware, Georgia, Maine, New Hampshire, Ohio, Pennsylvania, Tennessee, Texas and Wyoming. These grants support advocates in their efforts to bring the voice of babies and toddlers to public policy at the federal, state, and local levels. Since the Better Baby Care Campaign was launched in 2001, Better Baby Care activities have been initiated in 31 states and the District of Columbia.

For core Better Baby Care Principles, see <www.betterbabycare.org>. For examples of state and local initiatives see <www.betterbabycare.org/state_local_main.html>.

Moving Forward

Working with more vulnerable families is hard, sometimes frustrating work, but it is also rewarding and challenging. The examples cited in this report illustrate that even in the face of continuing budget cuts, high staff turnover rates, and often times greater demands on those who work directly with the most vulnerable babies and toddlers and their families, programs and communities have been able to:

- Develop effective outreach and engagement strategies to provide earlier interventions to those at greatest risk.
- Provide services at critical times of need, such as police involvement and domestic violence support services.
- Enhance collaboration across systems and service providers, such as child welfare services and early intervention services.
- Mobilize the needed range of skills and staff to address the range of family needs, such as drug and alcohol treatment, early childhood development services, early intervention, psychologists, health practitioners, and social workers.
- Provide mental health support and reflective supervision practices for staff working with the highest-risk families.

Important challenges both from a resource as well as a clinical perspective also face the field. These include the need to:

- Develop culturally appropriate and effective treatments for both parent and child depression and mental illness, particularly for immigrant and refugee families.
- Find and retain high-quality and appropriately skilled staff and provide resources to address staff depression and job stress among those working directly with infants and toddlers.
- Build "healthier" partnerships among child protective services, early intervention, mental health, substance abuse treatment, and domestic violence services in the context of the broader early childhood agenda.
- Promote a research agenda among local programs that includes not only outcome data, but also information on how well programs are actually implemented. Lessons from Early Head Start evaluations suggest that this is key to moving to a new level of program effectiveness.

Helping the most vulnerable infants, toddlers, and parents is not easy, but if we fail to do so, the consequences will most surely spill over into the next generation.

Ten Principles to Guide Policy, Practice, and Advocacy

The following principles for action are based on the wisdom, insights, and principles of those who informed this report.

1) Start with the parents, but connect with the whole family—not just the mother and the young child—and don't forget the fathers, wherever they are.
2) Work in partnership with community leaders (promoters, mentors, resource moms, and others).
3) Target important moments and transitions in families' lives (such as pregnancy, birth, entrance into early childhood programs, probation/incarceration).
4) Connect with families as early as possible (starting during prenatal care is best).
5) Connect with families across as many settings as possible (such as churches, other faith-based organizations, informal child care providers, and resource and referral agencies).
6) Use multiple entry points for access to family-focused screening, assessment, prevention, and more intensive treatment (such as community health clinics, family court, juvenile justice system, substance abuse programs, and shelters).
7) Make sure that parenting programs are responsive to the special needs of more vulnerable families.
8) Nurture the staff. Make sure there are supports for child care staff that are depressed, stressed, and burnt out (such as access to early childhood mental health consultation).
9) Find ways to use existing funding more efficiently, and then seek new funding for specific purposes.[41]
10) Train the next generation of professionals with real families as their teachers, especially families who have overcome burdens. For example, assign medical and other graduate students to a family with a new baby for a year to understand the context of stressed families' daily lives, their celebrations, and hardships.

Conclusion

Each year, over 4 million young children are born, many of them into loving, nurturing homes regardless of family income. For those less fortunate, it is in the public interest to invest in interventions that can help change a negative development course to a positive one. The strategies highlighted in this document provide a framework with which to start. Helping the most vulnerable infants, toddlers, and parents is not easy, but if we fail to do so, the consequences will most surely spill over into the next generation.

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APPENDIX A
Vulnerable Infants, Toddlers, and Families Conference: Participants List

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Family Options: Caring Understanding Solutions
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University of New Mexico
SELECTT and GRO Programs

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Executive Director
Rhode Island KIDS COUNT

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Child Outcomes Research and Evaluation
Office of Planning, Research, and Evaluation
Administration for Children and Families
U.S. Department of Health and Human Services

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Associate Professor of Clinical Pediatrics and Psychiatry
Albert Einstein College of Medicine
Director, Rose F. Kennedy Early Childhood Center
Bronx, New York

Joelle-Jude Fontaine
Program Officer
A. L. Mailman Foundation
White Plains, New York

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Director of Research and Minnesota Child Response Initiative
University of Minnesota, Department of Psychology,

Walter Gilliam, Ph.D.
Assistant Professor of Child Psychiatry and Psychology
Yale University Child Study Center

Ellinor Goldberg
Executive Director
Maine Children's Alliance

Anne Goldstein, M.A.
Director, State Policy Initiatives
Zero to Three: National Center for Infants, Toddlers, and Families

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Deputy Director
Children's Futures Inc.
Trenton, New Jersey

Mary Hansell, R.N., Dr.P.H.
Director, San Mateo County Health Services Agency
Deputy Director, Public Health
San Mateo County Prenatal to Three Initiative

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National Early Head Start Coordinator
Head Start Bureau

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The Annie E. Casey Foundation
Baltimore, Maryland

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University of Maryland, Department of Human Development
Institute for Child Study

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Senior Vice President
Ounce of Prevention Fund
Chicago, Illinois

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New York, New York

Jill Lefkowitz, M.S.W.
Research Analyst
National Center for Children in Poverty
New York, New York

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Massachusetts Early Childhood Linkage Initiative
The Heller School for Social Policy and Management
Brandeis University

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Executive Director
A. L. Mailman Family Foundation
White Plains, New York

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Director, Early Head Start National Resource Center
Zero to Three: National Center for Infants, Toddlers, and Families

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Senior Associate
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Washington, DC

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Director
Early Head Start
Allentown, PA

Ruth Mayden
Director of System and Service Reform
Annie E. Casey Foundation
Baltimore, Maryland

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Associate Director of Child Development/Early Head Start
P.E.A.C.E., Inc.
Syracuse, New York

Anne Mentzer
Vice President, Program and Policy
Pennsylvania Partnership for Children

Martha Moorehouse
Director
Office of the Assistant Secretary for Planning and Evaluation
Office of Health and Human Services
U.S. Department of Health and Human Services

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Manager for Publications
National Center for Children in Poverty
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Executive Director
Voices for Greater Cleveland's Children

Sondra Wallace
Miami-Dade Community Action Agency HS/EHS

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Policy and Advocacy Specialist
Voices for America's Children
Washington, DC

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Area Director
Child Trends, Inc.

APPENDIX B
Contact Information for Resources

Action for Community Development, Inc.
Family Connection Project
178 Tremont Street
Boston, MA 02111
617-357-6000

Babies Can't Wait
New York State Permanent Judicial Commission on Justice for Children
140 Grand Street, Suite 404
White Plains, NY 10601
914-948-7568
www.courts.state.ny.us/ip/justiceforchildren/index.shtml

Baby FAST
Marilyn McDonald Ph.D., ACSW (FAST Program Founder)
Wisconsin Center for Education Research
University of Wisconsin-Madison
1025 W. Johnson Street
Madison, WI 53706
mrmcdona@facstaff.wisc.edu
www.wcer.wisc.edu/fast/how/Baby_FAST

Chicago Health Resources and Services Administration Perinatal Depression Project
Psychiatry, UIC
912 S. Wood Street
Chicago, IL 60612
312-996-7383
lsimanis@psych.uic.edu

Coordinated Rewards Illinois Babies (CRIB)
Penny Roth
Bureau of Family Nutrition, Illinois Department of Human Services
Springfield, IL 62702
217-782-2166
dhshpat@dhs.state.il.us

Every Child Succeeds
Children's Hospital Medical Center
3333 Burnet Avenue
Cincinnati, OH 45229-3039
513-636-2830
everychildsucceeds@chmcc.org
www.everychildhsucceeds.org

Family Options: Caring Understanding Solutions (FOCUS)
University of New Mexico
SELECTT and GRO Programs
317 Commercial Street NE, Suite 100
Albuquerque, NM 87102
(505) 272-3469

Homeless Children's Network
3625 17th Street, Suite 404
San Francisco, CA 94110
415-437-3990
hcninfo@pacbell.net
www.hcnkids.org

Incredible Years
Lisa St. George
1411 8th Avenue W.
Seattle, WA 98119
888-506-3562
LisaStGeorge@Incredibleyears.com
www.incredibleyears.com

Massachusetts Early Childhood Linkage Initiative
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The Heller School for Social Policy and Management
Brandeis University
415 South Street, MS 035
Waltham, MA 02454-9110
781-736-3843
lippitt@brandeis.edu

Miami Safe Start Initiative
Lynne Katz, Ed.D.
University of Miami
Department of Psychology
Linda Ray Intervention Center
750 N.W. 15th Street
Miami, FL 33136
lkatz@miamisafestart.org
www.miamisafestart.org

Nurturing Father's Program
Mark Perlman
Center for Growth and Development, Inc.
3277 Fruitville Road, No. 1D
Sarasota, FL 34237
mcperl@verizon.net
www.nurturingfathers.com

Nurturing Program for Families in Substance Abuse and Treatment Recovery
Norma Finkelstein, Ph.D.
Institute for Health and Recovery (IHR)
349 Broadway
Cambridge, MA 02139
617-661-3991
IHR@healthrecovery.org
www.healthrecovery.org

Ounce of Prevention Fund
Doula Services and Educare Center
122 S. Michigan Avenue, Suite 2050
Chicago, IL 60603-6198
312-922-3863
info@ounceofprevention.org
www.ounceofprevention.org

P.E.A.C.E., Inc.
217 S. Salina Street
Syracuse, NY 13202
(315) 470-3300
www.peace-caa.org

Pima County Prevention Partnership
Claire Scheuren
2525 East Broadway Boulevard, Suite 100
Tucson, AZ 85716-5398
520-624-5800 Ext. 1201
cscheuren@thepartnership.us
www.thepartnership.us

Raising Our Children's Kids (R.O.C.K.)
Michelle Moreno
4701 N. Keystone Avenue, Suite 150
Indianapolis, IN
mmoreno@kidwrap.org

San Mateo County Prenatal to Three Initiative
Mary Hansell
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San Mateo, CA 94403
650-573-2316
mhansell@co.sanmateo.c

Touchpoints™
Terry Ann Lunt, MPA
Brazelton Touchpoints Center
1295 Boylston Street, Suite 320
Boston, MA 02215
617-355-6947
touchpoints@childrens.harvard.edu
www.touchpoints.org

WestEd PITC
180 Harbor Drive, Suite 112
Sausalito, CA 94965-1410
415-289-2300
www.pitc.org

APPENDIX C
Additional National Resources

Better Baby Care Campaign
betterbabycare@zerotothree.org
www.betterbabycare.org

FrameWorks Institute
1776 I Street NW, 9th floor
Washington, DC 20006
info@frameworksinstitute.org
www.frameworksinstitute.org

Talking Early Child Development and Exploring the Consequences of Frame Choices
www.frameworksinstitute.org/products/frameworksmemo_1.pdf

National Center for Children in Poverty
The Mailman School of Public Health
Columbia Unviersity
215 West 125th Street, 3rd floor
New York, NY 10027-4426
info@nccp.org
www.nccp.org

National Scientific Council on the Developing Child
The Heller School of Social Policy and Management
Brandeis University
Mail Stop 077
Waltham, MA 02454-9110
info@developingchild.net
www.developingchild.net

Voices for America's Children
1522 K Street NW, Suite 600
Washington, DC 20005-1202
202-289-0777
voices@voicesforamericaschildren.org
www.voicesforamericaschildren.org

So You Want to Be a Voice for Babies: Tips from the Better Baby Care Campaign
www.voices.org/bbc/tipsheet_1

Zero to Three
National Center for Infants, Toddlers, and Families
2000 M Street, NW, Suite 200
Washington, DC 20036
202-638-1144
www.zerotothree.org

Building Bridges from Prekindergarten to Infants and Toddlers
www.zerotothree.org/policy/policybriefs/BuildingBridges.pdf

NCCP National Center for Children *in* Poverty
Columbia University
MAILMAN SCHOOL OF PUBLIC HEALTH

215 West 125th Street, New York, NY 10027
TEL 646-284-9600 ■ FAX 646-284-9623

www.nccp.org