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Early connections last a lifetime
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Raising the Quality of Services for Infants, Toddlers, and Their Families

FEATURED IN THIS ISSUE:

- A Home Visitor Guide for Management of Perinatal Depressive Symptoms
- Building Equity and Cultural Competency in the Birth-to-3 Early Intervention System
- Quality in Family Child Care Networks
- Workforce Development for Working With Infants and Toddlers

ALSO IN THIS ISSUE:

Social-Emotional Development, Families, and Mental Health Needs in the Earliest Years

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This Issue and Why It Matters

The earliest years of life are a time of tremendous growth and opportunity, and early experiences have lasting effects on future development. Thus, high-quality services must be a priority for programs and professionals serving families with infants and toddlers. This issue of *Zero to Three* explores a variety of innovative approaches to quality improvement. The articles focus on efforts to: improve the capacity of home visitors to address maternal depression, increase cultural competency and equity in the early intervention system, evaluate the effectiveness of family child care networks that have the potential for improving family child care quality, and create competency standards in early care and education programs.

A common theme throughout these articles is the fact that program quality is dependent upon the knowledge, skills, and supports of the professionals who are working with young children and their families. Ongoing professional development and program evaluation are critical factors in attaining high-quality services. In addition, programs and services are only as effective as the systems that support them. Unfortunately, services for infants and toddlers are all too often fragmented and difficult to access. Public policy plays an important role in creating effective systems and standards that ensure families with young children have the best possible foundation for a healthy start in life.

The ZERO TO THREE Policy Center offers a wealth of resources for strategies to affect policy change for young children and their families. Visit the Action Center (**www.zerotothree.org/public-policy/action-center**) to find ways to learn more or get involved, such as joining the Policy Network to stay informed about the latest issues affecting infants and toddlers, connect with other professionals and advocates, and learn strategies for supporting policy change. This campaign season is an excellent time to get involved in advocating for how our nation's leaders can support the needs of young children and their families. See the Policy Center's top 5 questions for the Presidential candidates, and get involved in ZERO TO THREE's Rally4Babies (**rally4babies.org**).

We hope you will join ZERO TO THREE in these and other efforts to promote high-quality early experiencers beginning in the prenatal period and throughout the earliest years of life so all children can reach their full potential.

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Perinatal Depression Algorithm: A Home Visitor Step-by-Step Guide for Advanced Management of Perinatal Depressive Symptoms

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ABSTRACT

Early childhood professionals do many things to support young families. This is true now more than ever, as researchers continue to discover the long-term benefits of early, healthy, nurturing relationships. This article provides an overview of the development of an advanced practice perinatal depression algorithm created as a step-by-step guide for home visitors working with mothers with depressive symptoms. The algorithm was developed in response to the number of elevated Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987) results observed by a network of Wisconsin home visiting programs working with mothers prenatally through the first years of the child's life.

Elizabeth is a home visitor who is scheduled for her first home visit with Rachel, a first-time mother. When Elizabeth arrives for the home visit, Rachel greets Elizabeth and lets her into the home, but Rachel is very quiet. As Elizabeth begins talking about the program and services she provides to families, she observes Rachel continues to be withdrawn and appears to be struggling emotionally. Elizabeth acknowledges parenting can be challenging and shares that she is interested in knowing how things are going for Rachel. Rachel shares that things are "really tough." Elizabeth asks Rachel if she is willing to answer some questions that will help them better understand how Rachel is feeling and to come up with a plan to help her. Rachel says she is willing to complete the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987) and talk with Elizabeth about what she would find beneficial.

Prevalence of Maternal Depression

Prevalence data on maternal depression reveal that untreated maternal depression is widespread, particularly among low-income women with young children. Published estimates state that 5–25% of all new mothers experience perinatal depression. Estimates surge to 40–60% of low-income women with young children exhibiting depression symptoms. Postpartum depression is one of the most under-recognized and potentially undertreated mental health disorders in women (Gaynes et al., 2005; Knitzer, Theberge, Johnson, 2008). Postpartum depression has far-reaching and significant implications for the mother's health and well-being; parental functioning; and the healthy growth, development, and physical safety of the infant (Knitzer et al., 2008; National Research Council & Institute of Medicine, 2009). The National Research Council and Institute of Medicine reported that mothers are significantly more likely to experience depression than fathers, and mothers living in poverty are more likely to experience depressive symptoms than middle-class mothers (Goyal, Gay, & Lee, 2010; National Research Council & Institute of Medicine, 2009). Elevated depression symptoms typically do not go away on their own, and many women continue to report ongoing and unresolved symptoms throughout their children's early years (Horwitz, Briggs-Gowan, Storfer-Isser, & Carter, 2009). According to research from the Center on the Developing Child at Harvard University (2009),

> *About 1 out of 11 infants will experience their mother's major depression in their first year of life, and the rates are even higher for mothers with previous histories of depression or those experiencing other stressors such as financial hardship, or social isolation.* (p.1)

Home Visiting and Depression Screening

Across the United States, home visiting is increasingly recognized as an important service strategy for strengthening families of young children. In recent years, the federal government expanded home visiting services through the Maternal, Infant, and Early Childhood Home Visiting Program (ZERO TO THREE, 2014). Several nationally recognized models have documented evidence of their impact on several outcomes for children and families (U. S. Department of Health and Human Services, n.d.). Home visiting programs implementing evidence-based program models can improve birth outcomes, child physical health and emotional development, maternal physical health and emotional development, school readiness, and child maltreatment prevention. Home visiting programs vary in significant ways—from the background and education of home visitors (nursing, social work, early childhood educator, and paraprofessional) to the types of populations served and the frequency and intensity of home visits (U.S. Department of Health and Human Services, 2015). Home visiting programs consistently find that home visitors are in a unique position to conduct depression screening, provide referral to mental health services, and support treatment efforts. Many home visitors develop long-term, trusting relationships with women and their families. Frequently, home visitors begin visiting women during pregnancy, a highly stressful time when the onset of depressive symptoms is detectible. Being in the home environment allows home visitors to observe mother-baby interactions, assess both functionality and changes in functionality over time, and provide ongoing information and support to the family. Research conducted on Early Head Start, which is one type of evidence-based home visiting program model, concluded that Early Head Start has a sustained impact on reducing depression 2 years beyond the end of the program (Chazan-Cohen et al., 2007). Several innovative approaches for addressing maternal depression in home visiting programs were detailed in the May 2014 *Zero to Three* journal. These innovations are building a body of empirical evidence for addressing maternal depression in home visiting. Given the prevalence of women experiencing perinatal depressive symptoms, many home visiting programs are encouraged to screen women for depression as a comprehensive approach to service provision (Golden, Hawkins, & Beardslee, 2011; Segre, O'Hara, Brock, & Taylor, 2012, Segre & Taylor, 2014). However, successful depression screening practice requires that home visitors are equipped with the skills and support needed to effectively navigate the complex array of concerns that arise when discussing mental health issues. The Urban Institute reported that home visitors often feel uncomfortable discussing depression, and they worry about being unable to engage a mother whose lack of interest is perhaps masked by underlying depression (Golden et al., 2011).

DEPRESSION SCREENING EXPERIENCES IN THE FIELD

The Early Years Home Visitation Outcomes Project of Wisconsin (Outcomes Project) is a network of eight home visiting programs dedicated to best practice service provision and collecting common outcome data. The Outcomes Project began systematic screening for perinatal depression using the EPDS in 2013 (Cox et al., 1987). Within the first month of conducting depression screening, one home visiting program reported that of the 28 women screened, 13 women reported concerns of self-harm. It is also noteworthy that 21 of the 28 women screened had scored a 9 or above on the EPDS which, for scores at that level program policy recommends the home visitor initiate a referral for a full assessment and evaluation of a depression diagnosis. Research supports the need for systematic evaluation of those who report suicidal ideation to identify those requiring urgent evaluation and care (Kim et al., 2015). In 2014, the first year of reporting depression screening results, the Outcomes Project reported that 39% of the 395 women screened in the calendar year using the EPDS exhibited depression symptoms (Children's Hospital of Wisconsin, 2014). This alarming number of women who have clinically significant symptoms of depression underscored the need to develop the advanced practice algorithm to guide home visitor practice in working with mothers with depressive symptoms.

The Outcomes Project staff heard clearly from home visiting practitioners that they needed to feel competent and confident in the support they provide to clients. In personal communications with home visiting staff, some home visitors revealed they often felt overwhelmed by trying to impact child and family outcomes when the mother is struggling so heavily with her symptoms. Home visitors also reported feeling at a loss for how to support mothers when they do not want to seek professional help or professional help is not available to them due to a variety of barriers. Furthermore, home visitors expressed concern about leaving a home when a client has expressed thoughts of self-harm or appears to be struggling with day-to-day functioning. Most home visitors completed basic training focused on the foundational knowledge and skills for screening administration, referrals, and support prior to the EPDS screening initiative. However, home visitors and their program managers requested advanced training to increase their confidence and skills to manage more complex concerns.

Developing a Perinatal Depression Algorithm

An algorithm is a step-by-step method for solving a problem or accomplishing a goal. The initial trigger for the development of an advanced practice algorithm was home visitors' reporting a high rate of women indicating thoughts of harming themselves during the depression screening process. Collectively, there is well-documented support for a comprehensive strategy to get women effective treatments and supports through a family-focused approach. (Golden et al., 2011; National Research Council & Institute of Medicine, 2009; Weinberg, 2013).

In 2013, a multidisciplinary team of experts from the fields of psychiatry, nursing, home visiting, and health care secured funding to respond to this urgent need in the field. The team developed and piloted a program with three components: an advanced practice algorithm to guide home visiting practice, a training curriculum to support the implementation of the algorithm in practice, and follow-up technical assistance to support home visitors and their supervisors as they use the algorithm.

The development of the algorithm and its related training was informed by several data collection strategies to fully understand the needs of those working in the field: Current practice analysis, qualitative analysis of the experiences of those providing and receiving services, and professional mental health guidance.

CURRENT PRACTICE ANALYSIS

Early on, the research team identified the need to understand the types of support activities home visitors were currently providing to women during the depression screening process. Initial research activities included a retrospective analysis of EPDS and related follow-up data collected by the eight home visiting programs participating in the Outcomes Project located in urban, rural, and suburban communities in Wisconsin from January 1, 2013, to December 1, 2013. The programs enter service data in the Secure Public Health Electronic Records Environment (SPHERE) database, which is used in Wisconsin to document public health practice including the practice of home visitation as part of some agencies' overall data management strategy (Landis, Kratz, Spaans-Esten, & Hanrahan, 2007). Maternal depression screening is documented in SPHERE with the EPDS. A score of 9 or higher or any thoughts of self-harm prompt documentation of follow-up by the home visitor in SPHERE. Home visitors documented their planned follow-up which included options for re-screening; increasing the number of home visits; providing information on depression; ideas for promoting physical and mental health; building protective factors; and referrals to medical providers, mental health professionals, therapy, and support groups. The records of 487 unique clients, some of whom were screened more than once, represented a total of 588 visits which were analyzed. This analysis provided a foundational understanding of the current practice of home visitors to screen and provide follow-up services to mothers (Wichman, Laszewski, Doering, Kuhn, 2015). Findings suggest that home visitors respond to clients with depressive symptoms with a variety of support strategies. The data further suggest the need for ongoing screening for all women to allow home visitors to monitor changes in clients' depressive symptoms. Using these results, the research team was able to fine tune the focus of the algorithm on key decisions and sensitive conversations to complement home visitor support activities.

QUALITATIVE ANALYSIS OF THE EXPERIENCES OF THOSE PROVIDING AND RECEIVING SERVICES

The algorithm development was also guided by the findings of several focus groups. Separate focus groups were conducted with home visitors, their supervisors, and clients receiving home visiting services. The goal of the focus groups was to: (a) understand how home visitors work with clients and (b) identify the training and technical assistance needed to effectively work with their clients. The focus group with home visiting clients sought to understand the home visitor-client relationship, how this relationship influences services related to depression screening, and to identify perceived barriers to seeking additional mental health services. The client focus group findings revealed that a trusting home visitor-client relationship is essential for open and honest conversation regarding struggles with depressive symptoms. In one client's own words, "They are not talking at us, but talking with us." This recognition of meaningful conversation and non-judgmental support was an important finding that guided the algorithm development and training. Focus group findings revealed that some mothers fear their children may be taken away from them if they disclose that they are struggling with symptoms of depression, a finding that is supported in the literature (Poole, Mason, & Osborn, 2006). By understanding the relationship clients have with their home visitors, the developers sought to provide guidance in having difficult conversations on the sensitive topic of depression and maternal functioning to maximize the likelihood of successful treatment.

The algorithm addresses the concerns that training on screening administration and referral alone was not enough to prepare home visitors to effectively support mothers with depressive symptoms. The algorithm incorporates the EPDS results and takes into consideration if there is concern that the mother is unable to care for herself or her infant, regardless of EPDS score. By broadening the context of the decision-making to include maternal functioning, the algorithm aids in identifying next steps for home visitors in the client support and management processes beyond EPDS screening results.

PROFESSIONAL MENTAL HEALTH GUIDANCE

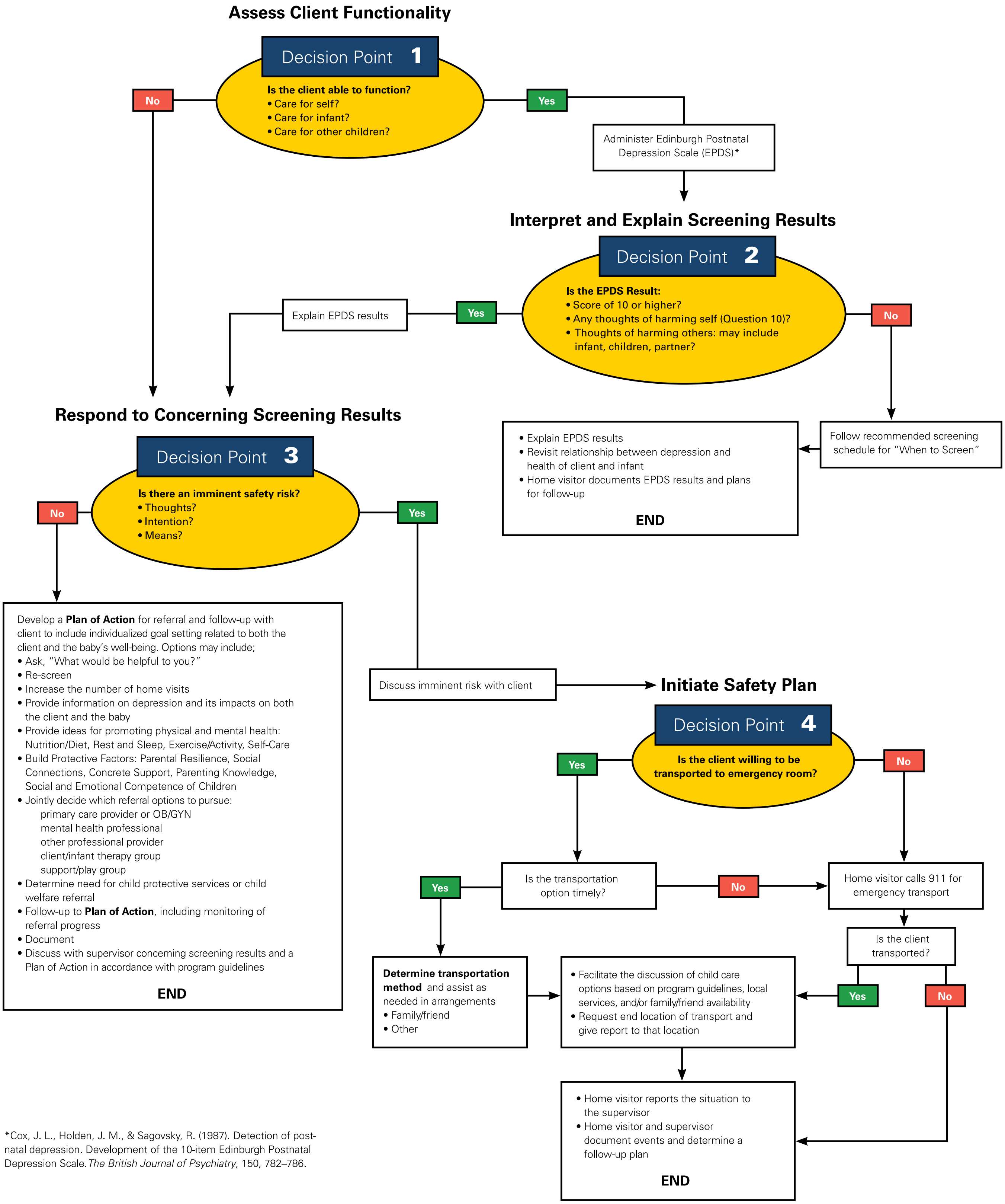
Clinical guidance and expertise of the research team's perinatal psychiatrist and doctorate-prepared registered nurse informed the framework of the four key decision points of the algorithm. This expertise also defined the appropriate role of home visitors in screening and support. Professionals from the fields of home visiting and prevention provided home visiting expertise as members of the research team. Evaluation services for the quantitative and quality data analysis were provided by staff from the National Outcomes Center of Children's Hospital of Wisconsin.

Algorithm Format

Four yes/no decision points serve as the basis of the algorithm and are framed as questions to guide home visitor practice (see Figure 1). The algorithm decision points include:

1. "Is the client able to function?"
2. "What is the EPDS result?"
3. "Is there an imminent safety risk?"
4. "Is the client willing to be transported to the emergency room?"

FIGURE 1. **Perinatal Depression Algorithm**



Assess Client Functionality

Decision Point 1

Is the client able to function?
- Care for self?
- Care for infant?
- Care for other children?

Administer Edinburgh Postnatal Depression Scale (EPDS)*

Interpret and Explain Screening Results

Decision Point 2

Is the EPDS Result:
- Score of 10 or higher?
- Any thoughts of harming self (Question 10)?
- Thoughts of harming others: may include infant, children, partner?

Explain EPDS results

Follow recommended screening schedule for "When to Screen"

- Explain EPDS results
- Revisit relationship between depression and health of client and infant
- Home visitor documents EPDS results and plans for follow-up

END

Respond to Concerning Screening Results

Decision Point 3

Is there an imminent safety risk?
- Thoughts?
- Intention?
- Means?

Develop a **Plan of Action** for referral and follow-up with client to include individualized goal setting related to both the client and the baby's well-being. Options may include;
- Ask, "What would be helpful to you?"
- Re-screen
- Increase the number of home visits
- Provide information on depression and its impacts on both the client and the baby
- Provide ideas for promoting physical and mental health: Nutrition/Diet, Rest and Sleep, Exercise/Activity, Self-Care
- Build Protective Factors: Parental Resilience, Social Connections, Concrete Support, Parenting Knowledge, Social and Emotional Competence of Children
- Jointly decide which referral options to pursue:
  primary care provider or OB/GYN
  mental health professional
  other professional provider
  client/infant therapy group
  support/play group
- Determine need for child protective services or child welfare referral
- Follow-up to **Plan of Action**, including monitoring of referral progress
- Document
- Discuss with supervisor concerning screening results and a Plan of Action in accordance with program guidelines

END

Discuss imminent risk with client

Initiate Safety Plan

Decision Point 4

Is the client willing to be transported to emergency room?

Is the transportation option timely?

Home visitor calls 911 for emergency transport

Is the client transported?

Determine transportation method and assist as needed in arrangements
- Family/friend
- Other

- Facilitate the discussion of child care options based on program guidelines, local services, and/or family/friend availability
- Request end location of transport and give report to that location

- Home visitor reports the situation to the supervisor
- Home visitor and supervisor document events and determine a follow-up plan

END

*Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of post-natal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *The British Journal of Psychiatry*, 150, 782–786.

Perinatal depression algorithm: A step-by-step guide for advanced management of perinatal depressive symptoms. Funding provided by Healthier Wisconsin Partnership Program of the Advancing a Healthier Wisconsin endowment of the Medical College of Wisconsin. Milwaukee, WI: Medical College of Wisconsin Inc., Children's Hospital of Wisconsin, University of Wisconsin-Milwaukee.

> *Focus group findings revealed that some mothers fear their children may be taken away from them if they disclose that they are struggling with symptoms of depression.*

The algorithm is accompanied with recommendations for who and when to screen (see box Setting the Stage for Screening). However, the research team recommends flexibility, recognizing that home visitor practice can vary by agency, home visiting model, and state policies.

Setting the Stage for Screening

Key elements to keep in mind when preparing to do screening include the following:

- Utilize reflective supervision.
- Ensure staff safety.
- Develop rapport/trusting relationship based on the stage of the developing relationship.
- Ensure privacy and confidentiality appropriate for the client's situation. For example, the client may complete the screen without vocalizing the response.
- Prepare home visitors with training on the Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987) administration and follow-up steps.
- Normalize the screening process.
- Provide the client with information on how perinatal depression impacts her ability to function.
- Offer the EPDS and follow-up conversation in the client's primary language when possible.

Who to Screen

All clients

When to Screen

Prenatally

- Ideally once per trimester, at least once prenatally.
- When there is a concern about the client's ability to function by the home visitor or the family.
- When there is a subsequent pregnancy before 12 months postnatal, screen at least once per trimester.

Postpartum

- Between 2–4 weeks postpartum.
- Between 8–12 weeks postpartum.
- Between 9–12 months postpartum.
- Rescreen at any time there is a concern about the client's ability to function reported by the client, family, or home visitor.

TRAINING

The algorithm is best used in conjunction with training that provides the clinical reasoning behind the decision points and incorporates sufficient time to observe and practice following the algorithm. During the piloting stage, training on use of the algorithm was held at three locations with 56 home visitors and supervisors representing eight home visiting programs. The 6-hour training was designed for home visitors previously trained in perinatal mood disorders and practiced in the administration of the EPDS tool. Home visiting program staff strongly recommended the training be led by mental health professionals. Home visiting representatives expressed concern with using a typical "train the trainer" format for the algorithm training session. Home visitors indicated it was important to develop the advanced practice skills under the guidance of professionals trained in addressing maternal depression. Sessions were led by a perinatal psychiatrist and a professor of nursing.

A training development consultant assisted with identifying specific learning objectives and created the training curriculum to align with the learning objectives (see Table 1). The sessions used a variety of adult learning strategies including: presentation of the clinical perspective of the importance of screening and assessing functionality, role play practice asking sensitive questions, observation of "real play", and implementation strategy worksheets to assist with integrating new knowledge and skills into practice. Home visitors reported the "sample phrasing" as an essential training component. Sample phrasing is language and phrase suggestions that assist the home visitor in guiding the conversation with the goal of gathering enough information to answer each of the decision-point questions. See box Sample Phrasing for an example of sample phrasing for first decision point.

ASSESSING TRAINING EFFECTIVENESS

Participants were given a pre-post survey to assess the training's impact on home visitors' confidence, comfort level, and skill in discussing mental health concerns with their clients. Using a 5-point Likert scale, respondents were asked to rate themselves on each of the learning objectives. Likert scales and mean scores are frequently used in medical education research when attempting to measure less concrete concepts like confidence (Sullivan & Artino, 2013). Response categories ranged from *strongly agree* (5) to *strongly disagree* (1).

Results showed that home visitors' confidence, comfort level, and skill were statistically significantly higher after completing the training (see Table 1).

The analysis demonstrated an increase in both confidence and competency in working with clients with depression symptoms across a variety of dimensions. Of the home visitors who completed the training, 96% indicated the facilitators' knowledge enhanced or aided their learning. This high rating is indicative of how important it is to have mental health experts lead the training.

TABLE 1. **PRE-POST Algorithm Training Results**

A value of 5 indicates *strongly agree* and 1 indicates *strongly disagree*.

LEARNING OBJECTIVES	PRE mean (median)	POST mean (median)	Statistical Significance of change*
I am able to identify changes in a client's ability to cope and to care for herself and others.	3.9 (4)	4.8 (5)	$p < 0.001$
I have confidence and competence in asking sensitive questions designed to assess a client's ability to function.	3.7 (4)	4.6 (5)	$p < 0.001$
I can demonstrate the use of communication skills that ensure trust when discussing screening results.	4.0 (4)	4.6 (5)	$p < 0.001$
I can confidently partner with clients in the discussion of next steps for support options.	3.6 (4)	4.6 (5)	$p < 0.001$
I know how to assess imminent risk.	3.3 (3)	4.7 (5)	$p < 0.001$
I can identify characteristics of a "Plan of Action".	3.2 (3)	4.5 (5)	$p < 0.001$
I have confidence with the decision-making process when a client is willing or unwilling to be transported to the hospital.	2.5 (3)	4.4 (5)	$p < 0.001$
I am able to communicate with the client and helping agencies when hospitalization is indicated.	2.9 (3)	4.5 (5)	$p < 0.001$
I understand the important role of supervision, documentation, and follow-up at each Perinatal DepressionAlgorithm Decision Point.	3.6 (4)	4.8 (5)	$p < 0.001$

*Paired *t*-test and Wilcoxon signed ranks test

The algorithm was refined after each training session and a final version was distributed to all participants upon conclusion of the pilot phase. Follow-up technical assistance was provided to sites via 1-hour conference call sessions with each location, held 3–6 months post training session. Technical assistance included the opportunity to discuss how the algorithm is working for them in practice, answer questions, and provide clarifying information regarding the use of the algorithm.

Using the Algorithm to Guide Practice

> *Elizabeth used the perinatal depression algorithm to guide her conversation with Rachel and to gain important information to assess Rachel's functioning, to understand her EPDS screening score, and to ultimately come up with a plan that Rachel was willing to try. After the visit, Elizabeth shared with her supervisor that the algorithm provided a framework for "comfortable conversation" and gave Elizabeth the confidence to ask sensitive questions to determine whether Rachel was at imminent risk of not being able to care for herself or her baby adequately. Elizabeth is convinced that she would not have been able to get such important information from Rachel had she not been following the algorithm. Elizabeth credits the algorithm training for gaining the knowledge, skills, and confidence to lead the conversation and jointly establish a plan for services.*

Sample Phrasing

The following presents sample phrases for use in answering the "Is the client able to function?" question on the Perinatal Depression Algorithm.

Client: "I just don't feel like myself."

Home visitor: "If you were more like yourself today, how would you feel different? What has changed? Let me give you some examples: Are you taking care of you? Getting out of the house? Taking a shower every day? How do you feel or what do you look like on a day when you are feeling well? That will help me so I can understand how far you are from your regular self. Let's try to get you back to where your normal is."

Summary and Recommendations

Initial piloting and use of the algorithm by home visiting has demonstrated its ability to increase the competency and confidence of home visitors working with mothers with depression symptoms. The algorithm and its related training have been incorporated into Wisconsin's statewide professional development system for home visitors and early childhood professionals as evidence of its contribution to the field. Other early childhood and community-based professionals working with clients struggling with depression symptoms may find value in reviewing the algorithm for use in their work. Members of the research team are working with other community service providers who have contact with new mothers to expand the use of the algorithm and related training. Based on these experiences, the algorithm holds promise as a worthwhile and useful tool for managing the screening and follow-up of clients with mental health concerns. The development team recommends potential algorithm users collaborate with their local mental health experts to provide training and support for its use in their community or state. Partnering with local experts provides users with the opportunity to customize the decision point conversations to their available resources and cultural considerations.

Acknowledgments

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Learn More

Children's Hospital of Wisconsin
Report on the Early Years Home Visitation Outcomes Project of Wisconsin
www.chw.org/~/media/Files/Childrens%20And%20Community/Abuse/2014%20Outcome%20Report%20%20WEB%20VERSION.pdf

Office on Women's Health
Provides information on a variety of women's health issues including mental health information and resources.
www.womenshealth.gov/mental-health

Postpartum Support International
Disseminates information and resources through its volunteer coordinators, website, and annual conference. Its goal is to provide current information, resources, education, and to advocate for further research and legislation to support perinatal mental health.
www.postpartum.net

PostpartumProgress.com
Provides peer-to-peer support and information for educational, advocacy purposes only.
www.postpartumprogress.com/about

For more information on the algorithm training discussed in this article, contact Audrey Laszewski at outcomesproject@gmail.com

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Jennifer Hammel directed the Fetal Infant Mortality Review Project which studied systems issues and barriers contributing to infant and fetal deaths in Milwaukee County. Hammel has worked in the child abuse and neglect prevention field since 1999 and has been involved in co-leading two major systemic initiatives that have transformed home visiting and outcome evaluation to a new level in Wisconsin. She has successfully managed two multiyear research projects as the community partner in community/academic research in early childhood home visiting.

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Errata

We regret that there were two errors in the January 2016 article "New Directions in Tribal Early Childhood Programs" by Kelli Bohanon, *Zero to Three, 36*(3), pp. 26–35. The name of the Port Gamble S'Klallam tribe was presented incorrectly. And the author's bio on p. 34 should state that she has served as adjunct faculty for the University of Washington.

Building Equity in the Birth-to-3 System: Who Is in the Room?

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ABSTRACT

The Birth-to-Three Equity Initiative launched in April 2015 as a multiyear systems change process to strengthen equitable access, services, and child and family outcomes in the "early intervention" system in Martin Luther King County, Washington. This article describes the training of agency leaders and "equity facilitators" that is underway to support universal access to a foundational level of training for all staff which addresses racism at individual, organizational, and systemic levels. The training also supports current staff members to strengthen their cultural competence with families they are already serving. The authors discuss how "Equity Change Teams" are being launched to support each organization's leadership and staff to analyze policies, procedures, and practices with an equity lens and to then develop and implement action plans to promote equity.

"Where does this word intervention *come from? Any time they talk about 'intervening' in our community it has meant trouble. Something not good was happening."*

The African-American mother who shared this powerful insight got right to the heart of a big problem. The program of supports for infants and toddlers with developmental delays or disabilities and their families is typically called "early intervention" or "Part C" services. When King County's Early Intervention program held focus groups to ask families and community members for feedback about the services, they learned that even the name was a problem for families.

But this mother was not just talking about the words "early intervention." Even if the name is changed, (and for now in King County the term is "birth-to-3" services), there are deeper problems. This participant in an African-American focus group was shining a light on the "cradle to prison pipeline" and how the birth-to-3 system in King County might play a role. Participants spoke of the many ways institutionalized racism in education, health care, child welfare, criminal justice, and other interlocking systems impact African-American communities with disproportionately negative outcomes for children and families. The birth-to-3 system is nestled at the intersection of early education, health care, and child welfare, and therefore also connected with the racism in those systems. Together the focus group considered how structural racism might relate to African-American children being underserved in birth-to-3 services nationally.

The women noted that in the education system, African-American students are over-identified for special education services in later grades, and families may be fearful of children accessing these services while only infants and toddlers. Many African-American parents themselves were likely misplaced in special education or may have had other negative experiences with school.


Photo: Shutterstock

Martin Luther King County, in Washington State, is a region roughly the size of Delaware, with just over 2 million people living in Seattle, 38 smaller cities, and expansive rural areas.

While many families see pediatricians who do not know about birth-to-3 services or how to make referrals, African-American families have additional concerns and challenges with the health care system. One participant, herself a physician, mentioned the lack of availability of African-American doctors combined with the reality that "Doctors are often uncomfortable with African-American families or fearful." This combination leads to many doctors' failure to hear parent concerns about their children's development.

In King County, as across most of the country, children of color are overrepresented in the child welfare system. Children who are involved in the child welfare system tend to have higher rates of developmental delays, with 50% or more likely eligible for birth-to-3 services, compared to 13% of children in the general population (Barth et al., 2008; Goode, Diefendorf, & Colgan, 2011). Furthermore, the long-term impacts of children who experience foster care include higher rates of homelessness and incarceration, both as youth and adults (Barth et al., 2008). One mother expressed her initial reluctance to participate in birth-to-3 services: "I was a young mom when my daughter was born with Down Syndrome. When the hospital told me they were sending a social worker to my house, I thought it was connected with child protective services." In fact, King County funds a completely different program, also called "Early Intervention," which sends public health nurses for home visits with families with open child protective services cases, completely unrelated to the birth-to-3 services discussed in this article. No wonder families feel threatened and confused when they hear about "early intervention" services!

Despite all of the problems parents described, the birth-to-3 system exists to support children with delays or disabilities to "catch up" or achieve their potential and to help families strengthen their advocacy skills and their children's development. By addressing child and family needs early on, birth-to-3 services have the capacity to prevent long-term health and educational challenges. For example, a significant percentage of children who access birth-to-3 services make enough extra progress that they are no longer developmentally delayed and may not need special education services as they grow older. In Washington State about 30% of children who access birth-to-3 services do not qualify for special education by the time they turn 3. An additional group of children who are served "catch up" by 5 years old. It is clear that birth-to-3 services are a big source of support for children and families, but could they also be part of the problem? We had to examine how the birth-to-3 system was contributing to systemic racism and change that!

Where We Are From

Martin Luther King County, in Washington State, is a region roughly the size of Delaware, with just over 2 million people living in Seattle, 38 smaller cities, and expansive rural areas. Although Seattle is one of the "most-white" large cities, the area also includes some of the most ethnically diverse zip codes in the country. King County was originally home to Duwamish, Snoqualmie, and Muckleshoot tribes, though at only 1.1% of the county's population, American Indians or Alaska Natives are now one of the smallest communities of color. Other groups include Asians at 16.4%, Latinos at 9.4%, Black and African-Americans at 6.7%, Pacific Islanders at 0.8%, and two or more races at 4.9% of the population in King County.

The region does have a long history of community organizing around social justice. The City of Seattle launched a Race and Social Justice Initiative more than a decade ago, and King County's Equity and Social Justice Initiative has been taking shape since 2008. The child care and early learning communities have had an even longer history of creatively and enthusiastically addressing racial equity and cultural and linguistic competency with support from local governments. Although participation ebbed and flowed in various education initiatives and social justice networks, few members of these groups were also engaged in birth-to-3 work.

King County's birth-to-3 system currently reaches nearly 4,000 infants and toddlers and their families annually with "Part C" services that are provided by 12 contracted agencies. By 2013 slightly more than half of the children receiving early intervention services in King County were children of color.

Photo: Susan Tripp

Equity facilitators Vincci Chan, Charlotte Jahn, Alifiya Khericha, and Suzanne Quigley take a break from facilitating small groups during Foundational Training.

During the same period 90% of the agency staff who worked with those families self-identified as white.

One quarter of the children who accessed birth-to-3 services in 2013 had a home language other than English—altogether reflecting more than 30 languages. Spanish-speaking families are the largest group, and whenever possible they are partnered with Spanish-speaking service providers. Interpreters are used very frequently, although sometimes an interpreter cannot be found, or parents request there be no interpreter, or alternate arrangements are made. Agencies have access to state-funded interpreters for children who have Medicaid insurance coverage, or fund the cost of interpreters when there is no Medicaid funding.

King County Developmental Disabilities Division sought a variety of community, family, and stakeholder input for its 3-year planning process for early intervention, including the focus group described previously. Families across King County shared many stories and experiences during the planning process. Two families' stories illustrate some of the equity challenges in King County's birth-to-3 system, which relate to access, services, and outcomes.

William and Nadia

William's family did not access developmental services before he turned 3 years old.

> *William was the youngest of four children in an active and engaged African-American family. He had numerous falls that landed him in the emergency room before he was 3 years old. The worst fall, off a ladder, caused a head injury and led to several days in the hospital. William's mother worked in an early learning program and was a strong advocate for her children. William was seen by many health care professionals who made comments such as, "Boys will be boys," but none of them expressed concern about his development or referred him for evaluation. Mom shared, "I am a persistent parent, and our family is fortunate to have access to insurance. My son was 5 years old before he was successfully diagnosed." Finally, a physical therapist diagnosed William with core instability, an easily treated condition, but not before the traumatic falls had impacted his brain development.*

So why didn't anyone refer William to birth-to-3 services, which might have prevented a long-term need for special education? Maybe his health care providers didn't know about the services or how to make a referral. They may have assumed that he was not well supervised and the parents were at fault. Or implicit bias about African-American children might have caused them to view William as "overactive" or "less innocent," rather than considering that he had a condition that led to falls (Keyes, Smyke, Middleton, & Black, 2015).

In King County, more than half of the likely eligible children between birth and 3 years old do not currently access services. This missed opportunity to address developmental challenges impacts nearly 6,000 children and their families per year.

Nadia's family did access birth-to-3 services when she was still an infant.

> *Nadia, who was born with Down Syndrome, was an only child in a family that had moved to the United States just after her birth. This family was quickly connected with a birth-to-3 agency which had several Spanish-speaking staff members. However, the mom's English was "so good" they were assigned to begin services with a motor therapist who did not speak Spanish. Both the mom and the therapist agreed that an interpreter did not seem necessary for communication during home visits. Unfortunately, the mom later shared that she did not feel comfortable explaining in English that she was feeling isolated and experiencing postpartum depression. The family was not immediately linked with the free counseling services the agency provided. Eventually Nadia and her parents were able to participate in a Spanish-speaking playgroup with other families and then began meeting with the Spanish-speaking social worker. Finally feeling well supported, the whole family became community leaders and strong advocates!*

Although Nadia's family accessed services early on, they were not initially culturally relevant. The negative impacts of services that were not culturally rooted, even though communication was "fine," were fortunately addressed by this agency, seemingly in time to prevent long-term negative outcomes. As one provider stressed, "It would always be best to do intervention in the family's native languages but we don't have staff with the wide variety of languages, and interpreters frequently derail the process."

A majority of families of color served in our community do not access linguistically or culturally responsive services, which ultimately impacts children's outcomes. Child social-emotional outcomes as measured during 2013 in the county's birth-to-3 system were disparate based on race. Children identified as white showed outcomes 5–8% percent higher than the county average, Latina/o children's outcomes were roughly at the county average, and other children of color's outcomes were 10–33% below the county average (King County Department of Community and Human Services, 2014). A community member framed the problem, "Families are not vulnerable because they are multicultural. They are vulnerable because the service system and information are not accessible."

These and many other challenges were identified by community stakeholders, who also participated in making recommendations about how to move the birth-to-3 system forward in King County (see box Excerpt From *The King County Plan for Early Intervention Services, 2014–2017*). Addressing and strengthening equity across the system was identified as the top priority.

Designing a Model for Engagement and Change

After the community articulated the urgency of addressing equity challenges in King County's birth-to-3 system and helped to identify strategies, the next stage was to design an approach for implementation. Several important steps included: gaining provider participation, identifying a consultant team, and creating a curriculum.

First, King County solicited input from the provider agencies on how to move forward. Provider feedback emphasized the following key elements:

- **Use a leadership development model**—Providers shared that, given their challenges with scheduling trainings, staff turnover, and sustained implementation of new approaches, a "Train-the-Trainer" model would be the best use of resources.
- **Elicit management buy-in**—Birth-to-3 program managers and agency directors wanted to participate in the initial training of equity facilitators, both to help to reinforce the value of the training and to signal their organizations' commitment to improvement and change.
- **Offer wide access to curriculum**—Over a 2- to 3-year period, all agency staff should be able to access the same training. Because of staff turnover, a system for training new hires would need to be implemented. Multiple delivery approaches should include professional development "modules" that could be provided at staff meetings throughout the year or combined for 2 full days of training.
- **Include racial equity approach relevant for working with young children and families**—The largest agency had already developed four training modules focused on understanding and undoing institutional racism, and all the providers sought access to this content. Agencies wanted their staff to understand the role systematic racism plays in the lives of children and families and how this knowledge can positively and specifically impact their daily work. Providers wanted to deepen their understanding of varied cultural perspectives about child development, family routines, developmental delays, and disabilities in order to support children and families effectively.

Excerpt From *The King County Plan for Early Intervention Services, 2014–2017*

Goal: Eligible children and families throughout King County who access EI [early intervention] services receive timely, culturally relevant, family-centered, individualized developmental services and supports from skilled providers who collaborate to meet child and family.

Objective 1—Increase access to culturally and linguistically appropriate EI services for children and families:

1. Identify and implement specific culturally and linguistically rooted strategies to increase family access, especially for underserved groups.
2. Provide training and resources for interpreters working in EI settings and for providers to work effectively with interpreters.
3. Provide training and technical assistance to agencies to recruit, hire, and retain bilingual and bicultural EI providers so that staff diversity will reflect the diversity of children and families in each service area.
4. Increase provider match of families with team members who speak their home language and understand the family's culture and, if no match is available, then create an individual plan around building provider cultural competence with/for the family.
5. Increase EI provider training to deepen staff understanding of the bilingual and bicultural communities they serve, to strengthen staff cultural competency, and to analyze provider policies, practices, and tools for bias.
6. Increase use of language and terminology that sets a positive tone with families and communities and allows for clear translations.

(King County Department of Community and Human Services, 2014, p. 46)

Developing a design that responded to provider needs and concerns was a first step toward ensuring their participation. With these key elements in mind, King County recruited the authors as a four-person "consultant team" to co-create and lead the initiative. The consultant team met multiple times starting in Fall 2014 to integrate the key elements, develop tailored content, and consolidate previous curricula into a unique 2-day "Foundational Training" for birth-to-3 staff. Altogether the consultants brought a variety of expertise with business, organizational development, education, early learning, and birth-to-3 services along with leadership in racial equity work. In addition, as a multiracial team with unique strengths and knowledge bases, we made great effort to tend to power dynamics and good communication. As part of getting to know each other personally and building trust and cohesion, team meetings included food, stories, and humor and took place in our homes.

King County committed 3 years of funding toward the initiative, including technical assistance to all 12 contracted birth-to-3 agencies paired with training for their staff members. The training and technical assistance was provided at no additional cost to providers in recognition that agencies would invest financially by allowing staff release time from their work with children and families. United Way of King County has also provided encouragement and matching funds for the initiative.

Curriculum Development—Foundational Training

The consultant team designed a 2-day Foundational Training with the intent that all birth-to-3 agency staff would have opportunities to nurture their "competencies" (see box King County Birth-to-Three Equity Initiative Competencies) using a mix of adult learning strategies—building knowledge, reflecting on experiences, listening to parents and other providers, and practicing skills. Whole group, small group, dyad work, and self-reflection are interspersed as are active engagement juxtaposed with listening deeply "with a hungry heart."

Five Basic Principles initially developed by the REACH Center for Multicultural Education are also woven throughout the curriculum (see box REACH Basic Principles). Each Foundational Training begins with a "Who's in the Room" exercise along with a reflection on who is not present. Over the 2 days, the content modules build from basic to more complex ideas: multiple perspectives, culture, children's racial identity development, implicit bias, microagressions, institutional and structural racism, and taking action.

One illustration of the braiding of competencies, adult learning strategies, and content is reflected in a series of activities related to "Where I'm From" (Christensen, 2000) to elicit the "head-heart-hands for healing" principle. After discussing this article (*head*), participants have the opportunity to listen to poems previously created by training assistants and a chance to work independently on composing their own poem (*hands*). In the morning of Day 2 they share their poem in dyads (*heart*), and write a chosen line on a sentence strip. Finally, for a connected closing of the whole training, participants read aloud a snippet from individual poems to blend a "Where We Are From" poem. This closing is a touching and inclusive way to reinforce the sense that "we're all in this together" (*healing*). Participants strengthen both "Awareness" and "Knowledge" competencies in the process and are often inspired to "Action/Advocacy."

The Foundational Training was also designed to be provided via 9 modules. Several additional modules will be developed in the coming months. Each birth-to-3 agency is encouraged to develop their own staff training plan. Some agencies are choosing to provide modules at staff meetings throughout the year; others have combined modules for a single full day of training, and King County will continue to make the Foundational Training available in the 2-day format quarterly over the next few years to ensure that all staff members have access.

King County Birth-to-Three Equity Initiative Competencies

This is an active, developmental, ongoing process and is aspirational rather than achieved.

Awareness—I am actively in process of becoming aware of my assumptions about human behavior, values, biases, preconceived notions, personal limitations, and willing to explore why I hold these beliefs. *Elements include* reflection on our cultural/racial lens, privileges, and relationship with internalized racial oppression.

Knowledge—I actively attempt to understand the world view of culturally diverse communities including values, assumptions, practices, communication styles, group norms, biases, experiences, and perspectives of culturally diverse children, families, communities, and colleagues. *Elements include* familiarity with bilingual-bicultural communities, disproportionate access, services or outcomes; multiple perspectives and relationships with delay/disability; racial identity development in children and adults; and institutional/structural racism—both history and current realities.

Skills—I actively develop and practice appropriate, relevant, and sensitive strategies and skills in working with culturally diverse children, families, communities, and colleagues. *Skills elements include:* Using culturally and linguistically rooted strategies to increase family access for underserved groups; working effectively with interpreters; interrupting bias, stereotypes, and micro-aggressions; and talking about race and racism with children, families, and co-workers.

Action/Advocacy—I actively advocate with and on behalf of the needs of children, families, and colleagues in my workplace and community to create and advance a culture of respect and equity. *Action elements include* facilitating conversations about race and racism; creating personal and organizational action plans; and leading/supporting analysis of policies and practices for bias and developing and implementing improvements. Agency action plans include organizational self-assessment; recruiting, hiring, and retaining bilingual and bicultural staff; and partnering with communities to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Adapted from Katz, 1978; King County Department of Community and Human Services, 2014; Office of Minority Health, 2013; Sue & Sue, 2003

REACH Basic Principles

The REACH Center for Multicultural Education, founded in 1978, is now housed at the Center for Education, Equity and Diversity at Western Washington University. A national network of REACH trainers has provided racial equity and cultural competency training throughout the country and the world. Locally they have also piloted "Early REACH" focused on preschool populations. REACH Basic Principles include:

- Actively engage multiple perspectives
- Recognize that culture is something everybody has
- Build cultural bridges
- Connect the head with the heart with the hands for healing
- Be a role model for co-responsibility

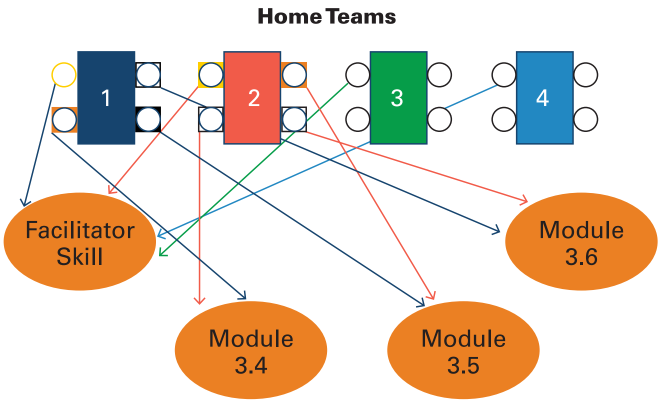
The first Foundational Training was held in April 2015 and served as the basis for initial outreach and a chance to recruit frontrunners. Roughly 50 participants included agency leaders and teams of birth-to-3 staff members who volunteered to become equity facilitators for their organizations. Adding a dozen community equity facilitators, who mostly work in early learning and infant mental health, created a more diverse pool of equity facilitators with greater experience leading professional development. The community equity facilitators did not have much previous partnership with early intervention. The interplay of these three "audiences" had a multiplier effect on the initiative's momentum.

Nurturing Equity Facilitators

The equity facilitators are provided with a variety of supports to build their leadership skills, familiarity with curriculum content, and capacity to launch an organizational equity change team. After completing the Foundational Training, equity facilitators attend Advanced Facilitator Training. This second level of training includes practice leading and adapting exercises from the Foundational Training and developing facilitation skills specific to equity work. Mini-lectures on "Facilitating Conversations About Race" and "Calling People In: Triggers, Challenges and Interventions" are additional content. But most of the advanced training is focused on building equity facilitator teams and community partnerships using an "each one teach one" jigsaw approach (see Figure 1). Equity facilitators are provided with written module and activity descriptions, and copies of *The Race and Social Justice Facilitators Handbook* (Philippian Group & Achievement Architects North, 2015) and *Diversity, Equity, and Inclusion: Strategies for Facilitating Conversations on Race* (Hollins & Govan, 2015).

The consultants also plan and co-lead a monthly community of practice gathering for equity facilitators to create a supportive environment for equity facilitators to build relationships and networks with each other. This work can be a challenging and sometimes lonely undertaking without strong allies. Each meeting includes a professional development topic to help deepen knowledge and practice facilitation. Equity facilitator teams discuss agency progress and challenges with their resource group, composed of one consultant and a small cluster of teams.

FIGURE 1. **The Jigsaw Process**



Jigsaw Process—Each One Teach One
1. Team Members break out to different study groups
2. Return to home teams to teach skills/info

Photo: Susan Tripp

Equity facilitators Miriam Zmiewski-Angelova, Janet Turner, Vincci Chan, and Anna Dodd share their stories about equity change work with children and families on the second day of Foundational Training.

Consultants are also available for on-site meetings with individual agencies in their resource group to plan, prepare for training, or support equity change teams. Equity facilitators are encouraged to include their consultant and community equity facilitators when they choose to provide training directly to their own agency.

Equity facilitators are also given the opportunity to build leadership skills by participating as training assistants with the county-wide 2-day Foundational Trainings. Initially, the training assistants observe and support the training, serving as scribes and table facilitators, and co-leading activities along with consultants. Once they have served in supporting roles, equity facilitators may then lead activities with shadowed support from consultant. The presence of equity facilitators during the Foundational Training offers more opportunities for participants to be heard and for the whole experience to be "held" thoughtfully.

Over the coming years, the increasingly experienced equity facilitators will be asked to serve as one of the four Foundational Training leaders, giving them the opportunity to work even more closely with consultants and allowing some consultants to step back. While not all equity facilitators wish to become trainers, the skills they are building will support taking leadership within their agency to launch equity change teams. Progressively increasing leadership roles will support equity facilitators in their long-term skills, challenges, and growth both as professional development leaders and racial equity change agents. The community of equity facilitators will be established as an ongoing network and the initially high level of support from consultants will gradually lessen.

Launching Equity Change Teams

While today's racial inequities don't exist because of "intentional racism," racial equity can only be realized via intentional actions. During 2016, each organization will be encouraged to plan for and launch an equity change team or comparable group to support the agency's ongoing equity work. Creating an agency-sanctioned and supported change team is one essential aspect of instituting equity across the birth-to-3 system. Participation of agency leadership and people in a variety of roles across the organization will be critical. Teams will engage in organizational self-assessment, followed by action planning which is ideally linked with the agency's strategic planning. Teams will build skills to apply a racial equity lens to programs, policies, initiatives, and budgetary decisions. These steps will help change teams to unpack the ways racism is inadvertently part of even the most well-intended work, and they can then develop equitable solutions. As each agency engages in more equitable practices in relationship to services, employment, and long-term planning, more equitable child and family outcomes within the birth-to-3 system as a whole are expected.

One equity facilitator team included their vice president for human resources and an early intervention program director. Within a week after the training, they were able to change their disenrollment policy and stay more engaged with families who previously would have lost services.

Early Successes, Challenges, and Insights

Barely a year into launching this initiative we are still gleaning, exploring, and considering many aspects of the approach, the content, and how to support continued enthusiasm and momentum.

RELATIONSHIP-BASED

Building and sustaining relationships as a focus of this initiative is essential on multiple levels. The relationships between the four consultants have flourished with "head, heart, and hands" as we plan, discuss, encourage, and learn from and with each other. The Foundational Training includes several relationship-building exercises to increase connections and relationships between participants and to ease transitions to more challenging topics later in the training. The consultant team strives to follow up when individuals or organizations have concerns about challenging content or struggle with discomfort. Acknowledgment of "ouch" moments and strategies for moving through are modeled in the context of trainings.

> *The Foundational Training includes several relationship-building exercises to increase connections and relationships between participants and to ease transitions to more challenging topics later in the training.*

Relationships between equity facilitators are strengthened through community of practice gatherings, teambuilding exercises, and the opportunity to co-lead trainings. Equity facilitator teams are supported to discuss and explore the ways internalized oppression might be impacting their teams even while they are also striving to lead for equity in their organizations. Community partnerships help to broaden the relationships and perspectives.

REFLECTIVE PRACTICE

When opportunities for reflection and sharing are built into the more challenging aspects of the content, participants seem more able to stay engaged. After the initial training, the curriculum was reviewed to identify whether any of the knowledge content could be scaled back to create more time for participants to process their emotional responses. Instead of content being eliminated, a 5-minute "think/write/pair/share" strategy was inserted several times throughout the trainings to create opportunities for reflection. Pacing, participant engagement, and group dynamics all seemed to improve when these reflective interludes are inserted. The reflection times also give consultants time to regroup and gain sight of the big picture or manage time over-runs. At the same time, the consultant team holds an intention about "struggling through" and recognizing this work cannot be done without discomfort.

A key component of the Foundational Training is sharing Day 1 evaluation feedback with the whole group at the start of Day 2, and using participant comments to make adjustments. Errors or miss-steps are acknowledged and modeled with the whole group as learning opportunities. Reflective practice is also a part of debriefing each training. Training assistants are asked to observe process, practice, and dynamics and take notes during the training. Their observations and suggestions are shared over lunch during the training, and they reflect collectively as a "panel" during the community of practice gatherings to build co-facilitation debriefing skills. The four consultants also take time to reflect on each training and integrate new ideas and suggestions when planning subsequent trainings.

COUNTERING STEREOTYPES, BIAS, AND STRUCTURAL RACISM

The consultants constantly attempt to override implicit and internalized biases by challenging assumptions and approaching our differences with inquiry. We strive to use humanizing language to communicate respect and cultural humility, such as "people first" terminology (e.g., people with disabilities, people who have experienced incarceration, people experiencing homelessness). This is a continuous process of checking ourselves, challenging ourselves, and considering the ways our own internalized oppression might be operating in the present moment. Despite King County's long history of racial equity work, we recognize that individual, organizational, and institutional racism are still operating and impacting our daily lives.

We have learned to pay attention to our equity facilitator teams and the various roles people play. Is a white person the leader, while people of color play more back-up roles? Are training assistants or panelists predominantly white and English-speaking? Are people of colors' skills and perspectives devalued or called into question more often than white facilitators? Are we paying disproportionate attention to the "discomfort" of white people? Do we conduct our trainings in a way that assumes that everyone can hear? These are the kinds of questions that the four lead facilitators are constantly asking and encouraging equity facilitators to ask. This can be a painful process and nurturing our "growth mindsets" supports everyone's continued engagement (Dweck, 2006).

MANY WAYS TO ENTER, TO GROW, TO CONTINUE

This initiative has emphasized inclusion and "calling people in," wherever they might be on their journey. A flexible and responsive approach has helped to get things rolling and all agencies participating. When some people couldn't make all of a session, we still encouraged them to come. Downsides to this flexibility include challenges with building relationships, and some people have not accessed all of the content. However the benefits have been even more powerful—people keep choosing to participate rather than opting out and partnerships keep growing.

Each team and the whole initiative is a dynamic process in response to changing needs. A few teams were initially small or did not have leadership involvement, but worked hard to recruit more people and engage leaders. Participants who have changed jobs were encouraged to continue their involvement and shift to a community equity facilitator role.

RIPPLE EFFECTS

The focus on all staff training and organizational change teams will also likely reverberate into other systems. Most of the agencies provide services in addition to early intervention, such as early learning, children's therapies, mental health services, family support, and adult employment. In addition, some of the equity facilitators are bringing training to other positions they hold—one mentioned training 20 therapists who work with seniors in assisted living at her second job.

Several community equity facilitators came from the same agency, Children's Home Society of Washington, and were encouraged to form their own team. Within a few months of becoming equity facilitators, this team offered full-day trainings to 150 staff members across the organization and engaged leadership with an agreement to provide all staff with Foundational Training in the coming year.

Photo: © istock/Creatista

When opportunities for reflection and sharing are built into the more challenging aspects of the content, participants seem more able to stay engaged.

FACILITATION IS ESSENTIAL

Co-facilitation in Foundational Trainings allows leaders of color and white leaders to work together and new facilitators to work with more experienced consultants. It also provides multiple perspectives and a balance and blend of facilitations styles and skills. Our hope is that by modeling co-facilitation, it will take place both inside and outside organizations, at every level of organizations, and across multiple organizations.

HELP PEOPLE FIND THEIR VOICE AS AGENTS OF CHANGE

All people have ongoing needs for support. The opportunity to practice leading offers engagement with each other and with the ideas. Some may not feel ready to lead, and some will go ahead before they are solidly ready. All leaders and participants have a role, and their presence helps each other step up. Engaging organizational leaders and staff at every level is essential for building change. Family and community voices are foundational to include at each step of the journey.

The executive director of one agency shared she had originally "signed up for the 1-day introduction to better understand the initiative and seek reassurance that it would be a good use of staff resources." Then she asked to become an equity facilitator and has led her staff to become the first agency with 100% of staff fully completing the Foundational Training as of November 2015.

So Is it Possible for the Birth-to-3 System in King County to Achieve Equity?

Clearly King County's birth-to-3 system is at the early stages of instituting equity, and much of the journey lies ahead. Can we work to ensure that William's, Nadia's, and all families access culturally and linguistically relevant services that promote the highest outcomes? Can we partner with systems in ways that institutionalize equity across all systems? Can we collaborate effectively with families and communities until we all agree, *"Something good is happening here?"* Let us borrow a response from co-author Benita Horn's grandfather, Pedro Silva, "Si, se puede!"

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Quality in Family Child Care Networks: An Evaluation of All Our Kin Provider Quality

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ABSTRACT

This article presents findings from a quasi-experimental evaluation of quality with a sample of 28 family child care providers in the All Our Kin Family Child Care Network,, a staffed family child care network which offers a range of services including relationship-based intensive consultation, and 20 family child care providers who had no affiliation with All Our Kin. The All Our Kin Network providers had significantly higher scores on a measure of global quality and on a measure of adult-child interactions than the comparison group. The results suggest that network participation contributes to improved family child care quality and have implications for future quality improvement efforts.

Although family child care is one of the most common child care arrangements for infants and toddlers, little research has focused on its quality or interventions to improve it. In June 2014, All Our Kin, a Connecticut-based nonprofit organization that operates a nationally recognized staffed family child care network which offers a wide range of services including relationship-based intensive consultation, began a partnership with an external researcher to conduct an evaluation to compare the quality of care offered by the All Our Kin Family Child Care Network family child care providers with similar family child care providers who had had no affiliation or contact with All Our Kin. In this article, we provide an overview of family child care; describe All Our Kin's model and the providers it serves; present the evaluation findings; and discuss the implications of these findings for policy, practice, and research.

> *Imagine you are at a child care conference with 100 people. The speaker asks you to raise your hand if your children were ever cared for by a family member other than a partner or a sibling, a friend or neighbor, or a regulated family child care provider. Forty-five people raise their hands.*

We often use this strategy to help people become more aware of the prevalence of home-based child care (care provided by regulated family child care providers or family members, friends, and neighbors who are legally exempt from regulation). The response reflects reality. Census data indicate that nearly half of all families with children under 5 years old whose parents are working regularly spend time in these types of nonparental home-based child care arrangements (Laughlin, 2013). Many of these families have low incomes and are of color (Laughlin, 2013). Findings from the 2012 National Survey of Early Care and Education (NSECE), a nationally representative survey of the early care and education workforce and families' use of child care, provide another perspective on home-based child care. Estimates of the size of the early care and education workforce indicate that the nearly 4 million home-based providers were close to quadruple the 1 million center-based teachers (NSECE, 2013).

Parents seek home-based child care for a variety of reasons (Porter, Paulsell, Del Grosso et al., 2010). Research has shown that parents value the family-like atmosphere with a small group of children in which the provider can offer individual attention to their

Photo: James Holmes

Providers at the All Our Kin Conference learn how to support social-emotional development in their programs.

infant or toddler (Porter, Paulsell, Del Grosso et al., 2010). They want the flexibility of a program schedule that can meet their needs for child care early in the morning, late in the evening, at night, and on weekends (Chaudry et al., 2011). The convenience of care in the neighborhood and the lower cost compared to center-based care play a role in their choices as well (Sandstrom, Giesen, & Chaudry, 2012). Some families also want a provider who shares their cultural values, language, and traditions (Porter, Paulsell, Del Grosso et al., 2010).

Data from the NSECE Household Survey supported these earlier findings (NSECE, 2014). Families with children under 3 years old were more likely to rate family child care as excellent on having a nurturing environment, a flexible schedule, and affordable cost than they rated center-based care (NSECE, 2014). Conversely, these families were less likely to rate family child care as excellent on educational preparedness and safety compared to center-based care (NSECE, 2014).

Family Child Care Quality

The NSECE family respondents' views on how well family child care providers can support children's readiness for school parallel, to some extent, research findings about the quality of family child care. Quality is an important issue, because research shows that high-quality child care is associated with positive child outcomes (Clarke-Stewart, Vandell, Burchinal, O'Brien, & McCartney, 2002; Elicker et al., 2005; Loeb, Fuller, Kagan, & Carrol, 2004). High-quality care is especially important for children who are at risk of poor readiness for school—those who live in poor families, who live in single-parent households, whose parents have low educational levels, and who experience stress (Brooks-Gunn & Duncan, 1997).

Like center-based care, the quality of family child care varies (Porter, Paulsell, Del Grosso et al., 2010a). Some studies that used the Family Day Care Rating Scale (Harms & Clifford, 1989) and its revised version, the Family Child Care Environment Rating Scale-Revised (FCCERS-R; Harms, Cryer, & Clifford, 2007), have found that, on average, quality is inadequate (Coley, Chase-Landsdale, & Li-Grining, 2001; Elicker et al., 2005; Fuller & Kagan, 2000; Fuller, Kagan, Loeb, & Chang, 2004; Kontos, Howes, Shinn, & Galinsky, 1995) or minimal to good (Paulsell, Boller, Aikens, Kovac, & Del Grosso, 2008; Raikes, Raikes, & Wilcox, 2005). Several of these studies found only small percentages of providers—7% to 10%—who provided care that was rated as good to excellent. Other studies that used such instruments as Quality of Early Childhood Settings Caregiver Rating Scale—Revised (Goodson, Layzer, & Layzer, 2005) and the Caregiver Interaction Scale (Arnett, 1989) have found that family child care homes were safe; that providers were warm, responsive, and nurturing; and that providers were engaged with the children (Coley et al., 2001; Fuller & Kagan, 2000; Layzer, Goodson, & Brown-Lyons, 2007; Peisner-Feinberg, Bernier, Bryant, & Maxwell, 2000).

STRATEGIES TO IMPROVE FAMILY CHILD CARE QUALITY

What strategies are effective for improving family child care quality? A 2010 review of the literature on home-based child care found 10 studies of interventions that aimed to improve family child care quality (Porter, Paulsell, Del Grosso et al., 2010).

Taken together, findings from these studies suggested that several specific types of strategies have the potential for improving family child care quality. These strategies include training through a workshop series, professional development through a credit-bearing or credential program, consultation in which a consultant works with a provider to jointly identify needs and then to develop a plan to address these needs, and a home visiting program model that combined two visits a month with monthly network meetings (Porter, Paulsell, Del Grosso et al., 2010).

Later studies supported and supplemented these findings. For example, an evaluation of training workshops with the Circle of Security model with All Our Kin Family Child Care Network providers found positive outcomes on providers' self-efficacy for managing children's challenging behaviors (Gray, 2015). Several studies of coaching—particularly coaching combined with coursework—have found positive effects on family child care practices (Isner et al., 2011; Moreno, Green, & Koehn, 2015; Neuman & Cunningham, 2009), and another study of home visiting showed positive outcomes on group family child care providers' readiness to change and the quality of the early literacy environments (Peterson & Weber, 2012).

There is some indication that family child care networks—organizations with staff that offer a variety of services to providers—have the potential to improve family child care quality, but research on the effectiveness of this approach is limited (Bromer, Van Haitsma, Daley, & Modigliani, 2009). Some studies have found that affiliation with a network was associated with quality (Doherty, Forer, Lero, Goelman, & LaGrange, 2006; Kontos et al., 1995).

Bromer et al. (2009) sought to examine the effectiveness of family child care networks in a study which compared family child care quality in networks with specially trained staff, networks without specially trained staff, and providers who were members of family child care associations. They found higher quality among providers in the networks with specially trained staff (Bromer et al., 2009). They also found specific network services that were associated with quality (see Table 1).

A qualitative study of home-based providers' perceptions of supports they received from specially trained staff indicated that providers learned about child development, specifically for infants and toddlers, how to arrange their environment, and new practices (Bromer & Pick, 2012). Many of the providers reported that their relationship with their specialist was trusting, comfortable, close and personal (Bromer & Pick, 2012).

> *I have learned that I have to have more patience with the children...But the younger kids... even though I know you have to give them time...it is hard to change your thinking, because I am like that. So, I am changing…yes…* (Bromer & Pick, 2012, p. 7)
>
> *Because while she is actually interacting with the children she's telling me what she's doing…and she's watching me and telling me what I'm doing…So she's reinforcing what I'm already doing.* (Bromer & Pick, 2012, p. 11)

All Our Kin

All Our Kin was founded in 1999 to train, support, and sustain community child care providers in New Haven, Connecticut. Although Connecticut is, overall, a wealthy state, it contains large pockets of severe poverty. Economic opportunity is particularly limited for families of color and those living in the state's under-resourced urban areas (TrendCT, 2015). Connecticut also has one of the largest academic achievement gaps in the nation between low-income students and their non-low-income peers (U.S. Department of Education, 2011).

All Our Kin's co-founders sought to address three interrelated problems—the lack of affordable, accessible child care options in struggling communities; the poor quality of existing child care options; and the low pay and lack of recognition for child care providers. They aimed to invest in family child care providers, who were, at the time, ignored by other organizations, scholars, and policymakers. All Our Kin launched the Family Child Care Network in 2002. All Our Kin expanded its services to Bridgeport in 2012, and then to Stamford and Norwalk in 2014. In 2014, the agency served approximately 360 caregivers with the capacity to serve up to 2,160 children. Close to 70% of the children in care were eligible for public child care subsidies (Waite, Carstensen, Coghlan, Graziano, & Parr, 2011).

TABLE 1. **Findings From the Family Child Care Network Study**

Findings from the Family Child Care Network Study	
Services associated with quality	**Services that were not associated with quality**
Provider training at the Network site	Referrals to training at other sites
Frequent home visits	Distribution of materials and equipment
Meetings with staff and providers at the network site	Business supports
Warm line	Peer mentoring

Source: Bromer et al., 2009


Photo: Tanya Michaelson

A family child care provider paints with a child.

Through All Our Kin's programs, family child care providers receive the training and resources necessary to provide high-quality, sustainable child care programs. In turn, these providers make it possible for parents to secure and maintain employment by providing reliable, consistent care that is affordable and accessible. Finally, by raising the quality of care in these home-based programs, All Our Kin supports infants' and toddlers' healthy social, emotional, physical, and cognitive development.

THE ALL OUR KIN MODEL

All Our Kin's services begin with the Family Child Care Tool Kit Licensing Program, which helps unlicensed family, friend, and neighbor caregivers meet health and safety standards, fulfill state licensing requirements, and become part of a professional community of child care providers. Licensure indicates that programs meet health and safety standards and operate under state supervision, provides the possibility of increased income by raising the number of children for whom providers can legally provide care and higher subsidy rates, and professionalizes providers' status as early childhood educators.

The centerpiece of the All Our Kin model is its Family Child Care Network, through which providers engage in educational mentorship, professional development, advocacy and leadership opportunities, and a network of relationships with other family child care providers. The Family Child Care Network was designed to use research-based practices in early childhood coaching and teacher mentoring. Providers affiliated with the Family Child Care Network convene for monthly meetings, workshops and classes, and an annual professional development conference. They have access to a "warm line" they can call for advice at any time, zero-interest loans and grants, financial management and education training, and marketing and referral opportunities. (See Figure 1.)

ALL OUR KIN SERVICES

The heart of the All Our Kin Family Child Care Network is program visits with All Our Kin's educational consultants, who have extensive training and experience in both child development and adult learning and who visit family child care programs to provide on-site coaching. The educational consultants partner with providers in goal setting, observation, practice, and reflection, modeling educational experiences and demonstrating new strategies to improve program quality. All services are bilingual to meet the needs of the 50% of All Our Kin's providers who speak Spanish as their preferred language.

All Our Kin's Family Child Care Network prioritizes relationship-building and a strength-based approach. Trust, respect, and cultural competency are at the core of the model. Connecticut does not require its family child care providers to engage in ongoing professional development, nor does it have a Quality Rating and Improvement System, so participation in All Our Kin's programs is completely voluntary and built out of providers' internal motivation to improve the quality of the care they provide. All Our Kin staff members deeply respect providers' expertise and commitment to quality, and this respect forms the basis for their ongoing relationships.

ALL OUR KIN'S CORE VALUES FRAMEWORK

The following values guide and inform All Our Kin staff members' work in the field:

Maintain High Standards

Set the highest standards for yourself. Never compromise on excellence. Strive to be a model of best practice. Be ambitious. Hold yourself accountable for the quality of everything you produce.

Focus on Strengths

Value children, providers, and parents, and respect their unique perspectives, backgrounds, and experiences. Start from a place of potential and positivity. Understand that an asset-based approach to change requires sensitivity, flexibility, respect, and commitment. Work in partnership with providers and parents to improve outcomes for children.

Place Relationships First

Create authentic relationships based on recognition of each person's individuality and grounded in mutual respect. Approach others without prior judgment. Work cooperatively and collaboratively with people at different educational levels. Be culturally and linguistically sensitive. Work hard at building community wherever you go, both inside and outside All Our Kin.

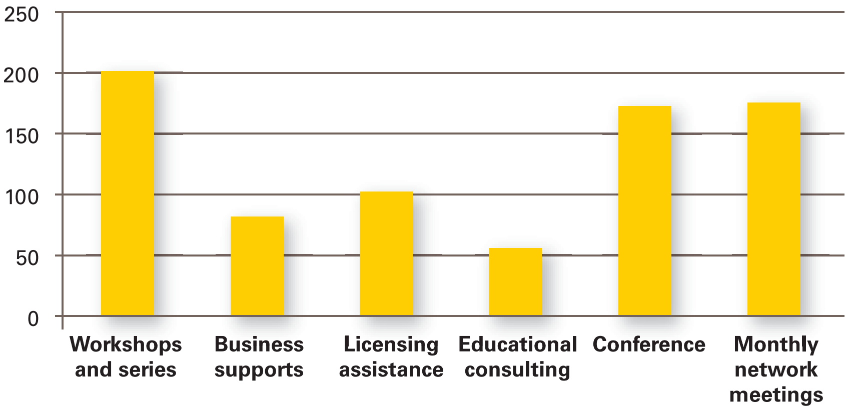
Commit to Transformative Outcomes for Children, Providers, and Families

Believe in and commit to the bold goal of quality early care and learning experiences for all children and equity for all caregivers. Continually ask yourself whether your work is improving outcomes for children and caregivers.

Engage in Continuous Learning

Seize every opportunity to gain more knowledge and use it to inform your work. Reflect on your experiences and change your practice in response. Be open to feedback and constructive criticism. Be humble, honest, and admit mistakes. Understand that we don't yet know all the right answers, and keep trying new strategies. Use data to inform your work. Persist in the face of obstacles. Experiment, innovate, and explore.

FIGURE 1. **All Our Kin Services, 2014 (*n* = 449)**



Note: The 449 participants included in this graph include the 363 caregivers in All Our Kin's regular programs (many of whom participated in multiple types of programs over the course of the year) as well as the 86 caregivers who attended only All Our Kin's conference.

The All Our Kin Evaluation

From its inception, All Our Kin has sought to understand whether it is making a difference for the family child care providers it serves. A 2011 evaluation documented its effects on the economic viability of providers' businesses through increases in their income and improving their levels of education (Waite et al., 2011). In a qualitative evaluation, providers reported increases in their understanding of child development and how to support it (Weiser & Susman, 2013). Providers also reported an improved sense of professionalism, attributing their decisions to pursue additional education or a Child Development Associate (CDA) credential to their participation in All Our Kin (Weiser & Susman, 2013).

Fifteen years after its inception, All Our Kin had become a nationally recognized model for improving quality in family child care. It had been profiled in a federally funded study of initiatives to support quality in these settings (Porter, Paulsell, Nichols, Begnoche, & Del Grosso, 2010), and it had been selected as a site for the Early Head Start Family Child Care Demonstration project (Del Grosso, Akers, & Heinkel, 2011). It was clear that All Our Kin needed additional evidence of its model's potential to improve quality in family child care. To address this need, All Our Kin sought to conduct a formal external evaluation. The evaluation aimed to examine two primary questions:

- How does the quality of care that All Our Kin's Family Child Care Network providers offer compare to the quality of care offered by family child care providers who are not affiliated with All Our Kin?
- What provider characteristics are associated with quality?

To examine these questions, we chose a quasi-experimental design that would compare the quality of care offered by All Our Kin's Family Child Care Network providers with the quality of child care offered by a group of other family child care providers in Connecticut who had no prior contact with All Our Kin.

STUDY MEASURES

Our methods consisted of a provider survey and observations with two instruments: the FCCERS-R and the Parenting Interactions With Children Checklist of Observations Linked to Outcomes (PICCOLO: Roggman & Cook, 2013).

The Provider Survey

The provider survey included questions about the following:

- The program schedule and the number and ages of children in care, because these characteristics may influence quality (Kontos et al., 1995; NICHD Early Child Care Research Network, 2005; Raikes et al., 2005).
- Selected provider demographic characteristics, including education, specialized education in early childhood including a CDA credential, and years of experience working in child care, because research has indicated that these characteristics are associated with quality (Doherty et al., 2006; NICHD Early Child Care Research Network, 2000; Raikes et el., 2005). In addition, we asked about provider race/ethnicity, age, and income.
- Six subscales that assessed provider attitudes and beliefs, because research suggests that provider personal characteristics are associated with quality (Forry et al., 2013). These subscales included items about provider motivation for providing child care, self-efficacy, social supports, depressive symptoms, beliefs about child rearing, and job stress. In addition, there was an item related to years intended to provide child care.


Photo: Tanya Michaelson

A family child care provider and a young child explore number and volume using rocks and a shoe.

The Observation Scales

The FCCERS-R observational instrument (Harms et al., 2007) uses 38 items grouped into seven subscales to measure the global quality of the environment. Each item is rated from 1 (*inadequate*) to 7 (*excellent*); subscale ratings are based on the average of the individual item ratings. Subscales include: space and furnishings, personal care routines, listening and talking, activities, interaction, program structure, and parents and provider (items related to the relationship between the parent and the provider).

The PICCOLO observational instrument (Roggman & Cook, 2013), which was originally intended to assess parent interactions with children, has been used in family child care (Norman & Christiansen, 2013) and in the Early Head Start evaluation (Roggman & Cook, 2013). It uses 29 items grouped into four subscales to measure the quality of caregiver interactions with children 10 to 47 months old. Each item is rated on a 3-point response scale with 0, *absent* (no behavior observed), 1, *barely* (brief or minor behavior), and 2, *definite* (strong or frequent behavior). Subscales include affection, responsiveness, encouragement, and teaching.

STUDY DESIGN

The target sample size was 30 All Our Kin Family Child Care Network providers and 30 non-All Our Kin family child care providers.

Photo: Janna Wagner

Family child care is one of the most common child care arrangements for infants and toddlers.

Study Eligibility

All providers had to be licensed family child care providers and caring for a minimum of three children, with at least one child between 10 and 47 months old, because PICCOLO observations are intended for children in this age group. Eligibility criteria for All Our Kin providers were designed to include providers who had participated in network services that focused on quality improvement. Between October 2012 and October 2014, providers had to have had a minimum of seven intensive consultation visits from All Our Kin educational consultants; and providers had to have participated in a minimum of 15 All Our Kin programs, with a minimum of 5 in 2014. All Our Kin providers who had participated only in the Tool Kit Licensing Project were excluded from sample eligibility.

Eligibility criteria for non-All Our Kin providers were designed to include only those family child care providers who had had no contact with All Our Kin. That meant that providers had never participated in any All Our Kin activities nor had they had the opportunity to participate.

We used e-mails and follow-up phone calls to recruit the eligible All Our Kin Family Child Care Network providers. For the non-All Our Kin providers, we sent letters to all 275 licensed family child care providers in Hartford, Waterbury, Danbury, and New Britain, all urban communities that shared some characteristics with the All Our Kin sites. We also made follow-up calls to these providers.

In total, 73 providers—30 All Our Kin Family Child Care Network providers and 43 non-All Our Kin providers—agreed to participate in the study, but 2 All Our Kin Family Child Care Network providers and 23 non-All Our Kin providers dropped out before the observations were conducted. Attrition was related to a variety of issues—family problems, the winter weather, and lack of provider response to scheduling the observation. Among the non-All Our Kin providers, there may have been a trust issue: some providers stated that they were not comfortable allowing anyone other than a state employee to enter their home. The final sample consisted of 28 All Our Kin Family Child Care Network providers and 20 non-All Our Kin providers. All participating providers provided informed consent and received a check for $100.

THE SAMPLE

Almost all of the providers in our study sample were women, the majority of whom were of color. More than two thirds had some college education or had completed an undergraduate degree. Approximately half had some specialized coursework or a degree in early childhood and close to half had obtained a CDA credential. Many providers had a great deal of experience providing child care. The only significant difference between the All Our Kin Family Child Care Network providers and the non-All Our Kin providers was the proportion of providers who reported having a CDA credential: 59% of the All Our Kin Family Child Care Network providers compared to 24% of non-All Our Kin providers. Because the All Our Kin Family Child Care Network offers CDA classes and scholarships, however, this difference may largely be a result of participation in the Network rather than a difference in demographic characteristics.

Many of the providers in the sample were poor or low-income. A quarter had incomes below $25,000, close to the 2014 federal poverty level (DeNavas-Walt & Proctor, 2015), and another fifth had incomes between $25,000 and $35,000, significantly less than $53,700, the federal median income in 2014 (DeNavas-Walt & Proctor, 2015).

All of the providers offered full-time care to children, and most of them cared for children with a variety of age ranges. Approximately 70% of the sample provided full-time care for infants and toddlers under 3 years old, and 39% provided part-time care to children in this age group. The only significant difference between the All Our Kin Family Child Care Network providers and the non-All Our Kin providers was in the mean number of children 18–23 months old in part-time care, where there was a higher average number of children with Network providers.

FINDINGS

In this section we report on the findings related to our first research question: How does All Our Kin family child care provider quality compare to the quality of care offered by non-All

Our Kin providers? The findings about personal characteristics related to quality are reported in the full study (Porter & Reiman, 2015).

Observed quality on both the FCCERS-R and the PICCOLO was statistically higher for the All Our Kin Family Child Care Network providers than non-All Our Kin providers. All Our Kin Network providers also had statistically higher scores on all of the FCCERS-R subscales and three of the four PICCOLO subscales than the non-All Our Kin providers.

FCCERS-R Scores

Mean global quality for the All Our Kin Family Child Care Network providers was 4.39, close to *good* (a score of 5) compared to a global mean of 2.86 (below 3, *minimal*) for non-All Our Kin providers. Mean scores on all the FCCERS-R subscales for the All Our Kin Network providers were also significantly higher than those for non-All Our Kin providers.

In addition, 64% of the All Our Kin Family Child Care Network providers were rated at 4 or above compared to 5% of non-All Our Kin providers. The proportion of All Our Kin Network providers with scores 5 and over in the *good* to *excellent* range was also higher than that for non-All Our Kin providers (29% vs. 5%).

An examination of the ratings of the 9 All Our Kin Family Child Care Network providers with FCCERS-R ratings of 5 and above showed considerably higher participation rates, and participation in a broader range of activities, than those for the 3 All Our Kin Network providers who were rated 3 and under. Mean participation in activities for the high-scoring group, for example, was 65.6 compared to 51.0 for the low-scoring group. In addition, the high-scoring group participated in a wider variety of activities—educational workshops, a business workshop series, and more years of intensive consultation—than the low-scoring group.


Photo: Tanya Michaelson

Licensure indicates that programs meet health and safety standards and operate under state supervision.

PICCOLO Scores

Mean total PICCOLO scores for the All Our Kin Family Child Care Network providers were higher than non-All Our Kin

providers' means (43.04 vs. 33.05, out of a total possible score of 58). There were also statistically significant differences in three of the four subscale scores, on which All Our Kin Network providers had higher scores than non-All Our Kin providers. The only PICCOLO subscale in which we did not find a significant difference between the All Our Kin Family Child Care Network and non-All Our Kin providers was "Responsiveness," although All Our Kin Network provider means were higher than those for non-All Our Kin providers.

Associations With Provider Professional Characteristics

Of the provider professional characteristics (education, early childhood education, CDA, and years of experience), we found only one—education—that was positively related to FCCERS-R and PICCOLO observed quality. There were no statistically significant correlations between specialized education in early childhood or a CDA credential and observed quality scores, nor was there a significant correlation between experience and observed quality. Regression analysis of FCCERS-R and PICCOLO scores indicated that CDA attainment was not a confounding variable.

DISCUSSION

The study demonstrates the potential of the All Our Kin model for supporting quality in family child care. All Our Kin Family Child Care Network providers' total mean scores and almost all of the subscales scores on both the FCCERS-R and the PICCOLO were significantly higher compared to those of non-All Our Kin providers. Furthermore, observed FCCERS-R global quality for the All Our Kin Network providers was higher than observed global scores reported for family child care providers in other studies as was the proportion of All Our Kin Network providers with FCCERS-R scores in the *good* to *excellent* category, 5 to 7, and there was a lower proportion of All Our Kin Network providers with ratings of *inadequate*, 3 or below.

What factors account for the differences in quality between the All Our Kin Family Child Care Network providers and the non-All Our Kin providers? Our study suggests that participation in All Our Kin Family Child Care Network activities may contribute to family child care quality. Although we do not know which specific activities—or some combination of activities—produces these results, prior research on the effects of coaching and consultation strategies points to the potential role of the All Our Kin intensive consultation component, with its emphasis on strong relationships between the specially trained consultants and providers as well as its focus on provider-child interactions. Yet, it is possible that other network activities such as the monthly meetings and the trainings may influence quality, as Bromer and colleagues' (2009) study indicated.

LIMITATIONS

There are several limitations to our study. The sample size of 48 family child care providers was relatively small. The study design was quasi-experimental with a treatment group and a comparison group, and, therefore, not as rigorous as a randomized control trial. There may have also been some selection bias, with providers enrolling in the study because they believed they provided high-quality care, and, in the case of the All Our Kin Family Child Care Network providers, loyalty to All Our Kin.

IMPLICATIONS

Our study has some important implications for policy, practice, and research. In many ways, the All Our Kin Family Child Care Network providers in the sample were representative of family child care providers who participate in All Our Kin Family Child Care Network services. Equally important, the All Our Kin sample's education levels and experience mirror those of the listed providers (primarily regulated family child care providers) in the NSECE workforce survey (NSECE Project Team, 2013).

Race/Ethnicity

To some extent, the All Our Kin Family Child Care Network sample's ethnic/racial characteristics reflected those of the All Our Kin participants who had received direct services in 2014. Latinos represented the highest proportion of providers in the sample (52%) and the All Our Kin participants (61%), and African-Americans accounted for the second largest proportion in both the sample and the participants served, 30% and 25% respectively. The primary difference between the sample and the All Our Kin participants was the proportion of whites. Whites accounted for 15% of the study sample, and 9% of All Our Kin participants in general.

Educational Levels

The educational levels of the All Our Kin Family Child Care Network sample providers mirrored, to a large extent, those of the NSECE-listed providers. Approximately 30% of the All Our Kin Network sample had a high school degree or less compared to 34% of the listed providers, and another 30% had some college with no degree compared to 34% of the NSECE listed providers. Higher proportions of the All Our Kin Network sample had an associate's degree or a bachelor's degree and higher than the NSECE-listed providers: 19% of All Our Kin Network providers with an associate's compared to 16% of the listed providers, and 22% of All Our Kin Network providers with a bachelor's or graduate degree compared to 16% of the listed providers.

Experience

All Our Kin Family Child Care Network sample providers' years of experience working in child care was comparable to that of the listed providers in the NSECE. Approximately 40% of the All Our Kin Network sample providers had 10 years or less experience compared to 37% of the NSECE listed providers. The percentage of All Our Kin Network sample providers with 10 to 20 years and more than 20 years of experience was also similar to those of the NSECE listed providers: 36% of All Our Kin Network providers with 10 to 20 years compared to 36% of the listed providers and 24% of the All Our Kin Network providers with more than 20 years of experience compared to 27% of the listed providers.

Income

The proportion of All Our Kin Family Child Care Network sample providers (22%) with incomes between $25,001 and $35,000 was higher than the proportion of families in New

Haven County, 7.4% (U.S. Census Bureau, 2013). Similarly, 28% of All Our Kin Network sample providers had incomes between $35,001 and $50,000, far higher than the percentage of families in New Haven County (9.9%; U.S. Census Bureau, 2013). By contrast, close to 70% of New Haven county families had incomes above $50,000 compared to 28% of All Our Kin Network sample providers.

Because of the providers' similarities and the multiple ways All Our Kin Family Child Care Network providers scored higher on key instruments, the All Our Kin Family Child Care Network model may represent a promising strategy for improving the quality of family child care. The results also suggest that the All Our Kin Family Child Care Network approach may have potential for enhancing child care quality among family child care providers and for families who have low incomes, the target population for public child care subsidy programs.

The findings on All Our Kin Family Child Care Network provider quality compared to that of non-All Our Kin providers may also have implications for practice. We need to understand more about how networks contribute to quality, particularly about the role of network staff qualifications and in-service training. We also need to learn more about effective ways to support staff who work with providers in various ways.

In addition, our study points to the need to examine the effectiveness of specific network services and the ways in which these services might work together to improve quality. Related to this research is the need to examine the effects of network services for specific types of providers—those who are new to the field, those who have some experience, and those who are seasoned. Such research will help contribute to an understanding of how network resources, which may be limited, can best be used to meet providers' needs and improve quality.

Conclusion

As staffed family child care networks are increasingly viewed as promising strategies for improving child care quality, especially for infants and toddlers, this study suggests that a family child care network that provides strong relational supports and a focus on provider knowledge and practice may have a positive effect on quality.

Several fundamental questions remain. Do family child care networks make a difference for children, especially infants and toddlers? What is the relationship between the quality of family child care networks, the quality of care that their members offer to children, and child outcomes? Answers to these questions can contribute to strengthening the All Our Kin model as well as to the field's understanding of how family child care networks like All Our Kin's represent effective strategies for improving quality for young children.

Toni Porter, MA, formerly senior researcher at Bank Street College of Education, is a principal in Early Care and Education Consulting. Her research focus is regulated family child care and family, friend, and neighbor care. She has conducted evaluations of initiatives to improve quality in these settings and served as the principal investigator of a federally funded study of supporting quality in home-based care.

Kayla Reiman has worked as All Our Kin's research and evaluation fellow since graduating from Wesleyan University in 2014. She works with staff to improve data collection and analysis systems with the goal of improving organizational effectiveness.

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Learn More

All Our Kin
http://allourkin.org
For the full 2015 All Our Kin evaluation as well as other reports on All Our Kin. The website also includes information about the All Our Kin Family Child Care Network activities and other earlier evaluations.

Child Care and Early Education Research Connections
www.researchconnections.org
For more information about a wide range of studies on home-based care, the National Center for Children in Poverty has produced *Home-Based Child Care Quality Improvement: A Research Resource List.* It is a compilation of studies on family child care and family, friend, and neighbor care grouped into seven categories: policy issues and options for home-based child care; characteristics, needs, interests, experiences, and perspectives of providers and caregivers; factors affecting quality in home-based settings; measuring quality in home-based settings; evaluation of QRIS-based quality improvement interventions; evaluation of specific quality improvement strategies and interventions; and overviews, summaries, and reviews of quality improvement strategies and interventions.

National Survey of Early Care and Education
www.acf.hhs.gov/programs/opre/research/project/national-survey-of-early-care-and-education-nsece-2010-2014
For information about the National Survey of Early Care and Education (NSECE), including reports on the characteristics of teachers and caregivers from the workforce survey, perceptions of early care and education and survey instruments from the household survey, and predictors of quality as well as fact sheets on the characteristics of home-based providers and early care and education during non-standard hours. The NSECE instruments are also available.

Professional Development for Family Child Care Network Staff and Agency Specialists
www.erikson.edu/family-child-care-modules
This is a series of professional development modules for family child care network staff and agency specialists. Research reports on the Erikson Institute Family Child Care Specialist Training Project are available at www.erikson.edu/research/family-child-care-specialist-training-project. For more information about the Training and Research project, contact Juliet Bromer at jbromer@erikson.edu.

Jessica Sager, JD, is the executive director of All Our Kin. After graduating from Yale Law School, she co-founded All Our Kin, a Connecticut-based nonprofit dedicated to training, supporting, and sustaining family child care providers, with Janna Wagner in 1999. For the past 15 years she has been active in local, state, and national initiatives to improve the quality of family child care. Together with Ms. Wagner, she co-teaches a course on "Child, Care, Society and Public Policy" at Yale. She is a Pahara Aspen Fellow.

Janna Wagner, MEd, is the chief learning officer and co-founder of All Our Kin. Janna holds a bachelor's degree in psychology from Yale University and a master's degree in education from Harvard Graduate School of Education. She taught in the South Bronx through Teach for America and then joined the staff of the Boston Public Schools' Center for Leadership Development before founding All Our Kin with Jessica Sager in 1999. Ms. Wagner is a 2014–2016 ZERO TO THREE Fellow.

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ABSTRACT

The science is unequivocal in showing that infants and toddlers begin learning very young, and the workforce must be equipped with the specific skills and practices to fully support this important period of development. A major conclusion in the 2015 report from the Institute of Medicine and the National Research Council, *Transforming the Workforce From Birth Through Age 8: A Unifying Foundation*, was that although much is known about how children learn and develop, this knowledge is not reflected in current practices in the very diverse early childhood workplaces. Nor is there cohesion in the complex landscape that influences young children's development. To narrow its task, the Committee that produced the report focused on the foundational knowledge and competencies needed for all adults with professional responsibilities for young children. In this article, the authors review the report's recommendations for adults who have the enormous privilege and responsibility of caring for infants and toddlers.

In 2015, the Institute of Medicine and the National Research Council convened the Committee on the Science of Children Birth to Age 8: Deepening and Broadening the Foundation for Success to explore the science of child development and the implications for the professionals who work with children birth through 8 years old. The project resulted in the publication of *Transforming the Workforce for Children Birth Through Age 8: A Unifying Foundation* (Institute of Medicine & National Research Council, 2015).

Educator practices outlined in the report that support infant and toddler development include working in small groups; assigning a primary educator; and actively constructing an environment to support cognitive, language, and social skills and emotional regulation. In small groups, educators are able to structure the environment to maximize intentional interactions that are driven by the child's interest. Specifically, the educator builds upon and expands the child's experiences to facilitate new discoveries. For continuity from home to care and education setting, it is important that a primary educator stays with the infant or toddler over time and also understands the cultural values of the families being served.

Special Consideration for Working With Infants and Toddlers

In identifying quality practices for working with infants and toddlers, the report concludes that there are special considerations for working with this population to promote optimal development and early learning. We address several here:

1. Small groups: Caring for infants and toddlers in small groups is essential to minimize noise, distractions, and confusion. Small group size can promote intimacy between the educator and the infant. In small group settings, educators can identify and work toward needs and developmental progress of individual infants.
2. Primary caregiving assignments and continuity of care: Each infant and toddler should be assigned a primary educator who is responsible for establishing a relationship with the child and ensuring their comfort in the child care setting. The science indicates that a secure attachment to a primary caregiver(s) allows young children to approach learning opportunities more positively and confidently.

3. Instructional practices. Educators can support the growth of cognitive activities in the learning environment by using child-directed language during social interaction, playing sorting and counting games, putting into words describing the child's activities, and engaging in imitative play. In sum, the educator provides infants and toddlers with cognitive stimulation and embeds that stimulation in social interaction that provokes young children's interest, elicits their curiosity, and provides an emotional context that enables learning. Educators assume an active role in structuring the environment in this "purposeful play-based curriculum" (p. 253). This approach "advances the standard of the oft-cited dichotomous choice between entirely educator-directed and entirely play-based" (p. 253) instruction.
4. Environment, safety, and health: An inviting and safe environment enhances interactions and encourages exploration. The environment is also important in ensuring the health and safety of all children in the early care and educational settings.
5. Cultural and familial continuity: Educators should understand the cultural values of the children they serve, which can facilitate strong relationships with families and help create continuity for children across home and care and education settings.
6. Language-based interactions to develop trusting bonds: Consistently responding to infants' and toddlers' communication with talk and encouragement that is emotionally attuned will strengthen the attachment relationship while at the same time building language skills.
7. Talk for learning: Ongoing exposure to elaborate language, simple requests, and questions that draw out children's first words and phrases all support language development.
8. Engage in language-rich play: Play is a means of learning in early childhood. The guidance and facilitation of the educator is key in maximizing language-rich experiences. The educator can scaffold the language experiences—for example, asking questions, narrating events, and encouraging peer interactions. Educators can also model collaboration using language.
9. Read a variety of books and reread favorites: Reading to young children, including infants and toddlers, can create an engagement with books and also builds language and communications skills.

A major focus of the Committee was how to prepare all educators for all children in the early childhood years, not just infants and toddlers. Indeed, the Committee detailed the Foundational Knowledge and Competencies for All Adults With Professional Responsibilities for Young Children (see box). All professionals need to know how a child develops and learns, including cognitive development, socioemotional development, and physical development and health. All professionals need to understand the importance of consistent, stable, nurturing relationships, and protective relationships that support development and enable children to fully engage in their learning. All professionals also need to know that biological and environmental factors can interfere with development, behavior, and learning.

Moreover, all early educators must use their acquired knowledge and develop the necessary skills to (a) engage in

Foundational Knowledge and Competencies for All Adults With Professional Responsibilities for Young Children

The committee identifies the following general knowledge and competencies as an important foundation for all adults with professional responsibilities for young children.

All adults with professional responsibilities for young children need to know about

- How a child develops and learns, including cognitive development, specific content knowledge and skills, general learning competencies, socioemotional development, and physical development and health.
- The importance of consistent, stable, nurturing, and protective relationships that support development and learning across domains and enable children to fully engage in learning opportunities.
- Biological and environmental factors that can contribute positively to or interfere with development, behavior, and learning (for example, positive and ameliorative effects of nurturing and responsive relationships, negative effects of chronic stress and exposure to trauma and adverse events; positive adaptations to environmental exposures).

All adults with professional responsibilities for young children need to use this knowledge and develop the skills to

- Engage effectively in quality interactions with children that foster healthy child development and learning in routine everyday interactions, in specific learning activities, and in educational and other professional settings in a manner appropriate to the child's developmental level.
- Promote positive social development and behaviors and mitigate challenging behaviors.
- Recognize signs that children may need to be assessed and referred for specialized services (for example, for developmental delays, mental health concerns, social support needs, or abuse and neglect); and be aware of how to access the information, resources, and support for such specialized help when needed.
- Make informed decisions about whether and how to use different kinds of technologies as tools to promote children's learning.

Source: Reprinted with permission from *Transforming the Workforce for Children Birth Through Age 8: A Unifying Foundation* (2015), p. 496, by the National Academy of Sciences, courtesy of the National Academies Press, Washington, DC.

quality interactions with children; (b) promote positive, social development and behaviors; and (c) be able to understand and mitigate challenging behaviors. Professionals must be able to distinguish normal behavior from atypical behavior and make appropriate referrals for specialized services, if needed. As children become more exposed to technology, professionals need to make informed decisions of how and when to use technology to promote children's learning.

Recommendations for Workforce Development

The recommendations in the report reflect the complexity of development over the period of birth through 8. Specifically, the report stated that educators need to have a shared foundational knowledge and set of professional competencies that are matched with the changing developmental needs and capacities of infants, toddlers, and young children. The Committee pointed out that educators interact with diverse families and must understand and respect a multitude of backgrounds, cultures, and family structures that define the current population of young children entering care and early education programs today. In addition, the report highlights the need for educators to use developmental assessment tools to identify areas of potential intervention to maximize the full potential of each child. One key recommendation in the report asserts that constructing and managing intentional learning environments skillfully necessitates a solid educational foundation in child development, language, and learning that can be achieved with a bachelor of arts degree that fully supports the multiple dimensions of learning and professional development adults need to work with young children to ensure they are on a pathway to positive development.

The *Transforming the Workforce* report put forth 13 recommendations to improve professional learning and policies and practices related to the development of the workforce providers that care and educate children from birth through 8 in the following key areas: (a) higher education, (b) professional learning through ongoing practice, (c) evaluation and assessment of professional practice, (d) the role of leadership, (e) interprofessional practice, (f) support for implementation, and (g) improving the knowledge base to inform professional learning and workforce development. Space prohibits a review of all 13 recommendations, but three are highlighted here. These specific recommendations emphasize the importance of competencies of all adults who work with all children and infants and toddlers. They also identify the overarching policy framework that points to the need for coherence in quality across settings and roles of professionals working with children, infants, and toddlers. Finally, these three recommendations highlight the parameters in the decisions that need to be made at the accreditation and governing levels in ensuring consistency in quality workforce practices.

RECOMMENDATION 1

Strengthen competency-based qualifications requirements for all care and education professionals working with children from birth through 8.

Photo: Kiwi Street Studios

In small groups, educators are able to structure the environment to maximize intentional interactions that are driven by the child's interest.

The Committee recommends that all government agencies and nongovernmental resource organizations at the national, state, and local levels review their standards and revise them as necessary to support all professionals who enter the profession.

The Committee chose the analogy of a tree as a useful way to characterize the diffuse landscape of professional roles (see Figure 1). The tree's roots represent how individuals enter into a role

FIGURE 1. **Professional Roles**

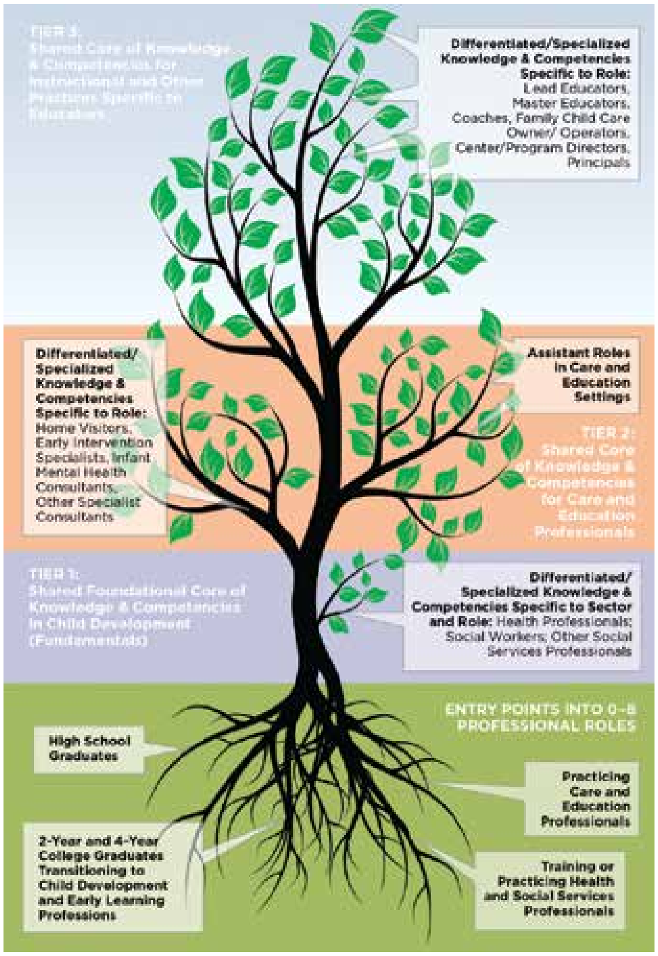

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Photo: Kiwi Street Studios

Each infant and toddler should be assigned a primary educator who is responsible for establishing a relationship with the child.

working with young children, the trunk represents a shared foundation, and the branches extend to represent specialized knowledge and competencies. The branches further differentiate into specialized roles and illustrate the progression from novice to experienced professional, including advanced education. These roles need to maintain connections to and alignment with others to support continuity of care and education and linkages to other professionals (see Figure 2).

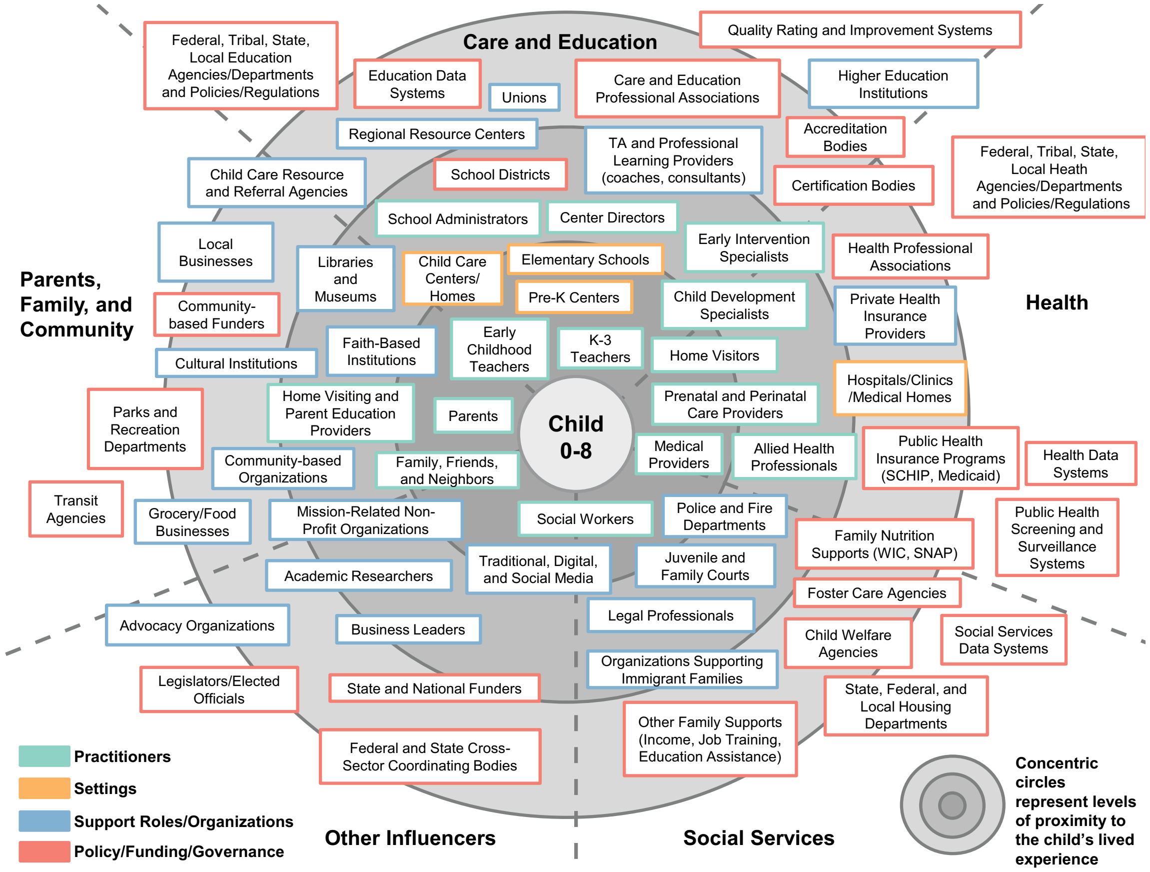
RECOMMENDATION 2A

State leadership and licensure and accreditation agencies, state and local stakeholders in care and education, and institutions of higher education should collaboratively develop a multiyear, phased, multicomponent, coordinated strategy to set the expectation that lead educators who support the development and from birth through 8 should have at a minimum a bachelor's degree and the specialization in the knowledge and competencies needed to serve as a care and educational professional.

RECOMMENDATION 2B

Federal government agencies, nongovernmental agencies, and nongovernmental resource organizations should align their policies with a multiyear phased strategy for instituting a minimum bachelor's degree requirement. They should develop incentives and dedicate resources from both existing and new funding streams and from technical assistance programs to support individual, institutional, systems, and policy pathways for meeting this requirement in states and local communities.

FIGURE 2. **Professional Roles**



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The complexity of constructing and managing intentional learning environments skillfully requires a solid educational foundation in child development, language, and learning that can be achieved with a bachelor's degree. This degree must fully support the multiple dimensions of learning and professional development that all adult professionals working with children in early care and education settings need to ensure they are on the pathway to positive development.

Conclusion

Early childhood professionals must have a core knowledge base to successfully help young children grow and develop. They must understand the emerging developmental science that underlies the domains of early learning and child development. Knowledge of subject content areas and concepts are equally important including language and literacy, mathematics technology, social studies, and art. Also in the core knowledge base is the recommendation that early childhood educators must know developmentally appropriate assessment principles and tools for culturally diverse children. Equally important, if not more so, are the practices that help young children learn, including managing the learning environment such as the physical space as well as classroom management. Productive daily classroom routines and the ability to use a variety of instructional and caregiving practices and curricula are skills and tools early educators need. The *Transforming the Workforce for Children Birth Through Age 8: A Unifying Foundation* report provides a blueprint for educators working with infants, toddlers, and young children. It could be used as a guide for decision making for not only professional preparation and development, but also can inform practice and practitioners.

Photo: Kiwi Street Studios

Educators interact with diverse families and must understand and respect a multitude of backgrounds, cultures, and family structures.

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REFERENCE

Institute of Medicine & National Research Council. (2015). *Transforming the workforce for children birth through age 8: A unifying foundation.* Washington, DC: National Academies Press.

Social-Emotional Development, Families, and Mental Health Needs in the Earliest Years

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Editor's note: The following is an excerpt from The Early Years: Foundations for Best Practice With Special Children and Their Families, *by Gail L. Ensher and David A. Clark, with contributing authors, to be published by ZERO TO THREE in April.*

For decades, scholars and researchers have acknowledged the essential roles of parents and caregivers in determining the trajectories of social and emotional development of their infants and young children (Bowlby, 1969; Brazelton & Sparrow, 2006; Cooper, Masi, & Vick, 2009; Coyle, 2011; Onunaku, 2005). However, it is only within recent years that child development specialists, educators, physicians, family counselors, psychologists, and other professionals serving our youngest populations have recognized the mental health issues of such populations within their respective "systems of care" (Osofsky & Lieberman, 2011, p. 120; Poulsen, 2013; Summers & Chazan-Cohen, 2012; Van Ornum, 2011). At least three often-related influences have been paramount in drawing attention to this pressing need:

1. The large numbers of infants and young children under 5 years old that are reported to child protective services as a result of abuse and neglect by their caregivers, parents, or others who may or may not be known to family members;
2. Communities and local neighborhoods plagued with violence and poverty; and
3. The growing numbers of family members with infants and young children who themselves are struggling with depression, anxiety, substance abuse, and other mental health disorders.

The fact that certain populations of infants and young children are more likely targets of child abuse and neglect within their families is also well documented. These groups include babies born prematurely, children born with impairments and disabilities, infants born to adolescent caregivers, young children under 5 years old who have been placed in the child welfare system, young children born into families of poverty with limited resources and education, infants and young children chronically exposed to violence and trauma, and families where parents have been deployed into the armed services (Ensher & Clark, 2011; Knitzer & Lefkowitz, 2006; Lieberman, 2010; National Research Council & Institute of Medicine, 2000; Nelson & Mann, 2011; Tronick & Beeghly, 2011).

In her presentation "Repairing the Effects of Trauma on Early Attachment," sponsored by The National Child Traumatic Stress Network, Alicia Lieberman (2010) defined *infant mental health* as:

- The capacity to grow well and to love well,
- The ability to express and regulate emotions and recover from dysregulation,
- The ability to establish trusting relationships and repair conflict, and
- The ability to explore and learn within the society's cultural values.

Given the normal course of variation in rates of development and individual differences in temperament, how does Lieberman's definition translate into typical patterns of social and emotional behavior and "healthy" mental well-being of infants, toddlers, and young children throughout the first 3 years of life?

Attachment, Security, and an Emotional Home

Most of the time, infants start life with all of the bio-neurological-sensory resources and social/emotional readiness to begin their journey toward learning how to relate to their closest family members and, eventually, people in their wider world. Attachment, bonding, security, and an emotional home with significant, consistent caregivers are the basic, requisite foundation for launching them onto this life-long pathway. Moreover, in many ways, healthy social and emotional development is the scaffolding for all other aspects of development. Echoing this point, Onunaku (2005) has written:

> *Babies are hardwired to develop strong, emotional connections, or attachment, with their primary caregivers. The ability to attach to a significant adult allows young children to become trusting, confident, and capable of regulating stress and distress. The most important part of attachment is the quality of attachment formed, as it predicts later development. Ideally,*

> *children develop secure attachment (a healthy emotional bond) with caregivers. Infants who develop secure attachment with a primary caregiver during the early years of life are more likely to have positive relationships with peers, be liked by their teachers, perform better in school, and respond with resilience in the face of adversity as preschoolers and older children. Attachment is integral to the emotional development of the young child; . . . babies need to become attached to at least one close, trusting adult.* (p. 4)

Everyday Care and Healthy Interactions

Nurturing between infant and caregiver during the early months after birth takes place within many biological, social, and emotional contexts that ultimately form the building blocks for trusting, caring relationships. During normal times of feeding and nursing, infants are able to hold their moms' and dads' faces in mutual, visual regard. Newborns are the parents' best teachers—of when they have had enough to eat, when they need to be picked up and comforted, when they are tired, when they have had too much stimulation, when they require quiet time, and when they have other unmet needs. Behavior—on the part of babies and the caregivers—is communication! Most important, caregivers soon discover that their newborns are unique, with different styles and patterns of emotional expression, with different temperaments, and with different levels of intensity and activity. All of these characteristics fall within the continuum and synchrony of "typical social and emotional behavior." Moreover, for caregivers and parents, "touching, holding, rocking, and talking are as important as getting the baby fed" (Brazelton & Sparrow, 2006, p. 57).

What Happens in the First 3 Years Really Matters: Trauma, Risk, and Toxic Stress

Those who have raised children likely would agree that being a parent or caregiver probably is the most challenging responsibility that they have ever had, with all of the uncertainties and ups and downs and few "hard and fast" rules and guidelines to follow. It is also evident that, in the 21st century, this responsibility is becoming ever more difficult with the fast pace of life; multiple roles that parents assume; increasing demands; and the growing hazards, pressures, and economics of day-to-day living. These mounting challenges are evident in the increasing numbers of families who struggle with mental health issues, as well as the growing numbers of children referred to child welfare and child protective systems because of suspected abuse and neglect. Further, it is well documented that the overwhelming numbers of children living in these often toxic situations are infants or young children less than 5 years old (Dicker, 2009; Ensher & Clark, 2009; Finello, Hampton, & Poulsen, 2011; Knitzer & Lefkowitz, 2006; Landy & Menna, 2006; Poulsen, 2013).

ADVERSITY WITHIN THE ENVIRONMENT AND ITS CONSEQUENCES

More than a decade ago, Shonkoff and Phillips (National Research Council & Institute of Medicine, 2000) emphasized the consequences of environmental/family adversity and stress for infants and young children that can and do take place as a result of early emotional impairments. These issues are as true today, perhaps even more so, as they were in 2000:

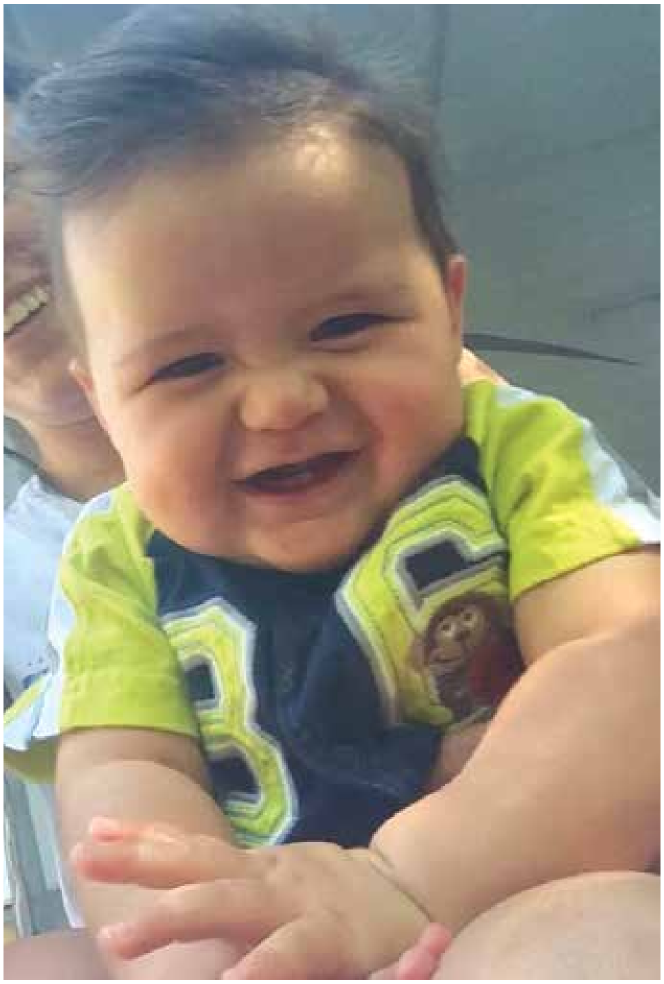

Photo: Jeanne Schmidt

The first 6 months of an infant's life is a period of great social and emotional learning, responsiveness, predictability, and growing exploration, as babies interact with the significant caregivers of their emotional homes.

> *Early child development can be seriously compromised by social, regulatory, and emotional impairments. The causes of such impairments are multiple but often revolve around disturbances in close relationships. Indeed, young children are capable of deep and lasting sadness, grief, and disorganization in response to trauma, loss, and early personal rejection. Given the substantial short- and long-term risks that accompany early mental health impairments, the incapacity of many early childhood programs to address these concerns and the severe shortage of early childhood professionals with mental health expertise are urgent problems.* (p. 387)

It is safe to say that the ecology of the world, local communities, and neighborhoods where parents and caregivers live and raise their infants and young children, have changed dramatically since Urie Bronfenbrenner's publication of *The Ecology of Human*

Photo: Jeanne Schmidt

Nurturing between infant and caregiver during the early months after birth takes place within many biological, social, and emotional contexts that ultimately form the building blocks for trusting, caring relationships.

Development in 1979. Safety in cities, in towns, on the streets, in public schools, in movie theaters, and on college campuses has become a serious concern in the United States, as seen in the tragically horrific events of Aurora, Colorado; Newtown, Connecticut; and more recently, Boston, Massachusetts. To be sure, violence in large cities, plagued with pockets of poverty, used to be the most frequent settings for such violence. In the early 21st century, however, this is no longer the case. Further, regardless of the position of people in terms of policies and regulations for gun control, families, legislators, educators, physicians, and professionals are now more aware than ever of the undetected mental health issues of adolescents and adults that have gone untreated, later to surface in unforeseen catastrophes such as those in Colorado and Connecticut. And even if families physically reside distances away from locations of tragedies, the realities are brought into their homes, over and over again, via the internet, cell phones, television, and other forms of technology that are within arms' length. The impact is significant for families, no longer comfortable and confident that they and their children are protected from harm's way.

The first of these major incidents took place on September 11, 2001, when families across the United States experienced terrorism, loss, and devastation on American soil, unparalleled in the history of this country. The severe psychological and mental health effects on parents and their children who witnessed these unimaginable events, either in person or via the media, have been the subject of much study for more than a decade (Chemtob et al., 2010; Gershoff, Aber, Ware, & Kotler, 2010; Melnyk et al., 2002; ScienceDaily, 2010).

On a smaller scale than 9/11 in terms of the loss of life and devastation, families continue to be ridden with anxiety around the acts of violence carried out in local communities and neighborhoods and schools, because they are happening in places assumed to be safe and protected from such atrocities. These events have dramatically changed the lives of families and young children forever! It is no surprise that the numbers of parents struggling with depression in the United States (emerging from multiple sources) is on the rise (now cited to be 1 in 10 adults; Centers for Disease Control and Prevention, 2010), mental health issues that are subsequently revisited upon their infants and young children.

Discussion about adversity within the environment would not be complete without addressing growing concerns about the effects of electronic media on infants, toddlers, and young children, referenced above. In addition to the exposure of children at very early ages to violence through news broadcasts and other technological venues on a daily basis, the widespread production and marketing of often developmentally inappropriate media materials for infants and very young children, from birth to 6 years old, have infiltrated almost every aspect of American family life. Schmidt et al. (2005), summarizing the findings of seminal studies on the effects of electronic media on young children, cautioned:

> *Media influences on young children are not only strong and pervasive, but also potentially controllable—especially in the early years when parents determine the majority of their children's media exposure. In order to ensure healthy media diets among children, it is important to understand how parents make decisions about their children's media use, so that effective interventions can be designed where appropriate. Anticipatory guidance and child-healthy advice about media use provided by pediatricians at "well-baby" visits can function as a "tipping point" to encourage parents to think carefully about the media their children consume.* (p. 11)

FAMILIES AT RISK

There is a wealth of research that highlights the adverse consequences of toxic family and environmental stress on infants and young children, emanating from discord and violence within home settings and beyond. In addition, multiple social, economic, and educational risk factors (Golden, McDaniel, Loprest, & Stanczyk, 2013), including the following, contribute to such problems:

- Poverty/poor economic resources including poor nutrition and unemployment
- Parental histories of child abuse and neglect
- Poor family supports and social isolation
- Teen pregnancy and adolescent caregiving
- Substance abuse
- Low levels of caregiver education
- Lack of information about positive approaches for guiding challenging behavior
- Unrealistic expectations of children by caregivers
- Single-parent families
- Parental depression and other mental health issues

Moreover, numerous studies on child abuse, neglect, and family violence have found that risk factors frequently coexist (Tronick & Beeghly, 2011), one or more hardships and stressors leading to additional situations, events, and challenges (Ensher & Clark, 2011), that perpetuate cycles of vulnerability (Tronick & Beeghly, 2011). Finally, underlying these findings is the fact that infants and young children from birth to 3 years old who are chronically exposed to toxic stress and adversity may experience neurological and social-emotional changes that have serious, negative consequences for later developmental and mental health outcomes. For instance, Shonkoff, Garner, and colleagues of the Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics (2012) wrote:

> *Advances in fields of inquiry as diverse as neuroscience, molecular biology, genomics, developmental psychology, epidemiology, sociology, and economics are catalyzing an important paradigm shift in our understanding of health and disease across the lifespan. This converging multidisciplinary science of human development has profound implications for our ability to enhance the life prospects of children and to strengthen the social and economic fabric of society. Drawing on these multiple streams of investigation, this report presents an ecobiodevelopmental framework that illustrates how early experiences and environmental influences can leave a lasting signature on the genetic predispositions that affect emerging brain architecture and long-term health. The report also examines extensive evidence of the disruptive impacts of toxic stress, offering intriguing insights and causal mechanisms that link early adversity to later impairments in learning, behavior, and both physical and mental well-being. . . .[The implications] suggest that many adult diseases should be viewed as developmental disorders that begin early in life and that persistent health disparities associated with poverty, discrimination, or maltreatment could be reduced by alleviation of toxic stress in childhood.* (p. e232)

CHILDREN AT RISK

The promising evidence noted previously, coupled with the identification of certain populations of infants and young children who often are more prominent targets of neglect, abuse, and toxic stress, holds much potential for early intervention and more positive developmental and mental health outcomes.

Researchers know, for instance, that the incidence of child abuse and neglect is considerably higher among:

- Infants and young children, 3 years old and under (Dicker, 2009; Wu et al., 2004)
- Infants born prematurely where bonding and attachment may have been compromised because of extended hospital stays (Summers & Chazan-Cohen, 2012)
- Young children in the child welfare system and foster care (Dicker, 2009)
- Infants and young children with learning, temperament, and behavioral challenges (DePanfilis, 2006; Goldman, Salus, Wolcott, & Kennedy, 2003).

The reasons for these noteworthy findings are many. Ultimately, these factors reflect multiple familial, cultural, racial, and environmental contributors, in the absence of sufficient caregiving and parenting supports to counterbalance negative agents, antecedents, and effects. Immaturities of parents, inadequate knowledge about positive approaches for guiding challenging child behavior, lack of knowledge and understanding of appropriate developmental milestones and abilities, poor choices of partners living in homes of infants and young children, parent overload of responsibilities with few community resources, caregiver inabilities to manage normal stressful periods of discontent of infants and young children, and growing problems of substance abuse all add to the mix of possible unsafe and/or adverse family situations. Moreover, in many instances, reaching families with *coordinated preventative efforts* across child advocacy and early intervention agencies has been a challenging, elusive task in the United States. Early intervention service providers, pre-k teachers, pediatricians, and medical and social services personnel in hospitals (should infants be admitted to pediatric or neonatal intensive care units) are frontline professionals who must be vigilant with regard to symptoms of family stress and adversity, as well as other obvious "red flags" related to child behavior and injuries (Ensher & Clark, 2009).

The "Tipping Point" for Developmental Outcomes

Despite the overwhelming "weight" of risk indicators that may lead to future mental health problems, there are infants and young children who somehow are "protected" from these influences, survive, and fare better than do other children. Indeed, as Hanson (2013) has noted, in the face of such adversity, "it is tempting to focus attention in education, health care, and the social services on what can and does go wrong; however, many things also go right in human development and within families" (p. 61). Identifying and strengthening these protective factors proactively can set a very different course and much more positive pathway for both caregivers and their young children.

Addressing the questions and issues about "resilience" and the variations among infants and young children, Ensher and Clark (2009) have written:

> *Some of the differences reside in the severity of exposure to violence, the presence of a significant other who can serve to "protect" the child, the age of exposure to maltreatment, the length of time during which the child was subjected to abuse and/or neglect, relief or removal from the violence, and child-specific characteristics. Most likely, resilience or an ability to adapt beyond adversity for more favorable outcomes ultimately will reside with the benefit of a combination of factors influencing any given child within the context of his or her family. Also, how professionals determine and who identifies*

> *positive outcomes and when in the lives of children those questions are examined may vary across agencies, teachers, or those making such judgment calls. Children change. They may "look" adjusted at one point in their lives; yet, given a different set of circumstances, they may need support and intervention at another time. Thus, on the continuum of living from day to day, these are indeed difficult determinations to make. However, there are children who, in reality, do better than others, and it is imperative to examine why and how that can be and then to translate that evidence into practice whenever possible.* (p. 281)

REVERSING THE ODDS OF RISK

In his insightful chapter "Resilience Reconsidered", Rutter (2000) wrote that family events and situations are fluid and dynamic. Just as multiple influences leading to "new morbidities" and later mental health problems for infants and young children likely coexist, it is equally probable that "multiple levels of influence" (Shonkoff et al., 2012, p. e234) can facilitate and promote healthier behavioral, social, and emotional outcomes for young children.

Essential foundations

Most scholars, researchers, policymakers, and professionals across multiple disciplines including early childhood education, special education, pediatrics, and clinical practice agree that reversing the odds of risk is a formidable task that will require a shift in paradigms, community resources, training and teaching, cooperation and collaboration across the respective fields of endeavor, and the family-centered interventions and practices. However, the focus will need to move from a deficit orientation to the adoption of a strength-based implementation, grounded in a commitment and ability to carry out policies and strategies of prevention. Professionals know, for instance, that:

- Secure, healthy, nurturing family relationships are essential to the well-being and development of young children.
- As indicated in Clark and Clark, (2016), good nutrition is critical to a positive course of physical, social-emotional, and cognitive/language progress. This needs to start prenatally and continue throughout a mother's pregnancy.
- Families under stress need to be reached before crises lead to child abuse and neglect. Many families in distress are isolated, without other family members and friends to assist, counsel, or support. Under the best of circumstances, raising and nurturing infants and young children is challenging.
- Accessible, affordable, and available pediatric care is essential to infants and young children throughout the first 3 years of life and beyond. These services need to be culturally and ethnically sensitive, as well as responsive to populations of caregivers who are diverse in terms of age, educational backgrounds, economic status, race, languages spoken within the home, family membership, locations of residence, and any special needs of their children.
- Addressing maternal mental health issues such as depression has the potential of greatly enhancing parent-child relationships, during the first 3 years and beyond, when the focus of effective intervention is the mother-child dyad (Shonkoff et al., 2012). With the documented growing numbers of caregivers struggling with such concerns, this area of adult and child health constitutes a major opportunity for intervention with mothers prenatally, throughout pregnancy, into the earliest months and years of life (National Scientific Council on the Developing Child, 2010).
- In the face of mild to moderate to severe disabilities, early intervention offered to infants and young children can change the trajectories of developmental outcomes, thus slowing and/or reducing the impact of disabilities (Goode, Diefendorf, & Colgan, 2011). This finding has important implications for infants and young children (birth to 3 years old) in the child welfare system (who are supposed to be afforded early intervention, as mandated by the Infants and Toddlers with Disabilities Program, Part C).
- Transition and implementation plans—from hospital to home, from foster care to parent homes, from early intervention to preschool programs and services—need to be developed and monitored. These important activities can be accomplished with the assistance of professionals such as EI teachers, social workers connected to the child welfare system, and pediatricians in medical home and community pediatric health care facilities who are likely to see and visit with families, their infants, and young children (Committee on Psychosocial Aspects of Child and Family Health, 2001).

WINDOWS OF OPPORTUNITY AT HOME: USING THE "TOUCHPOINTS" OF SOCIAL-EMOTIONAL DEVELOPMENT

Without a doubt, it is much easier to talk about problems and concerns related to the mental health issues of families, infants, and their young children than to effect real differences in real lives. On the other hand, there are some "windows of opportunity" for healthy social-emotional development of young children that are common to families representing very diverse cultures, racial and ethnic groups, levels of income and education, ages of caregivers, and styles of parenting. Pursuant to this assumption, as authors, we do not intend to minimize the challenges of changing the course of adverse or potentially toxic situations within families. On the other hand, it is possible that with utilizing a framework of relationship-based interventions, the following "touchpoints" can be helpful to professionals (partnering with families) toward fostering positive outcomes between parents and their children.

- **Using daily routines for developing nurturing, consistent, and quality caregiving/parenting practices with infants and young children.** These routines include a number of predictable tasks and activities that parents and their young children engage in as they communicate and interact. These "touchpoints" include feeding and mealtimes; changing, bathing, dressing, and eventually toilet-training; bedtime; and comforting and soothing during periods of child frustration and discontent.

  Lieberman, Padron, Van Horn, and Harris (2005) discussed "moments of particular connectedness, intense shared affect, and heightened intimacy between the parent and child" (p. 509) "as growth-promoting" and moments that are an "integral part of the child's identity" (p. 509). As authors, we are suggesting that as parents and their children participate in the daily routines of living together, such tasks, activities, and times offer essential opportunities for bonding, attachment, and growing together across the age span of the first 3 years. They are "teachable" moments for relationship building, learning, and "falling in love" that can serve as a springboard for professionals to enhance parenting and caregiving abilities.

- **Engaging in child's play.** Just as play is the child's most powerful way of learning, play is one of the most powerful means for relationship building between a parent and child. This reality is true for every stage of development throughout the first 3 years of life and beyond, regardless of a child's temperament, abilities, or learning or behavioral challenges. Play opens windows of opportunity for communication that can be shaped and adapted to a child's individual interests, preferences, and styles of learning. Play can take place within numerous settings and according to multiple formats. It can be spontaneous or initiated, it can be unstructured or structured, play can take place between caregiver and child or among several children, it can take place with toys and concrete materials or within imaginary or pretend contexts. Play can happen using gestures or prompts or with much verbal expression. In sum, the possibilities are endless! And perhaps most important, play can be a time for learning about one another through interaction, give and take, listening, self-regulation, developing social competence (National Association for the Education of Young Children, 2007), and giving of and expressing oneself—for child and caregiver alike. Emphasizing the importance of play in promoting healthy child development and maintaining strong parent-child bonds, Ginsburg (2007) wrote,

  > *Play allows children to use their creativity while developing their imagination, dexterity, and physical, cognitive, and emotional strength. Play is important to healthy brain development. It is through play that children at a very early age engage and interact in the world around them. Play allows children to create and explore a world they can master, conquering their fears while practicing adult roles, sometimes in conjunction with other children or adult caregivers. As they master their work, play helps children develop new competencies that lead to enhanced confidence and the resiliency they will need to face future challenges.* (p. 183)

  In sum, play is the essential right of every infant and young child.

- **Supporting appropriate child behavior.** Children learn what they live, and these "lessons" are transparent and transcending! A warm and developmentally supportive emotional home is the foundation of strong parent-child relationships. The effects of negative, violent, or traumatic home environments on infants are well documented (Ensher & Clark, 2011), as is the fact that "how parents respond when encouraging a particular developmental capacity in their child—such as self-esteem, attachment, or communication—is critically important" (Landy, 2009, p.xxi).

Photo: Lindsey Kurak and Kimberly Ensher

The greatest gift that professionals can give families with infants and young children with and without special care needs and disabilities is the realization of their own self-owned, self-discovered resilience, their abilities to grow and adapt, in the face of adversity.

- **Creating and maintaining a healthy and growth-promoting environment for the child.** In large part, the foundation of relationship-centered interactions between parents and their young children that are safe and growth-promoting are grounded in parents' basic understanding of child health and development In particular, parents must be able to create a safe physical environment at home; parents need to have age-appropriate, reasonable expectations of their children; and parents must raise their children with a common-sense awareness of age-appropriate nutritional needs and health-related concerns. Such guidelines and principles are vital to the well-being of all children, but especially so within the first 3 years of life when safeguards are paramount. Moreover, these needs and parenting practices necessarily change over time, as children grow; indeed, meeting these goals often becomes even more complex when a child has special needs and/or disabilities.

There are no easy answers to such dilemmas. Ultimately, parents and caregivers are most effective if they are supported by professionals as partners, rather than as the recipients of knowledge that they do not own or understand. Weston (2005) wrote:

> *It is humbling to come to the understanding that we do not have truth, that our professional, technical knowledge is best considered hypothesis in its relevance to this particular family and baby. When we understand that those with whom we work have "all the information we need . . . then our attitude conveys this" and the parent (and the child) can sense themselves as sources, partners, rather than as assessed and judged recipients.* (p. 346)

Implications for Families and Professionals

Proactively addressing the mental health needs of families, and infants and young children leads to better and less costly outcomes. Based on recent studies, many later-onset child maladies can be prevented if addressed in the early years.

To accomplish this preventative goal, parents and professionals need to work together as partners. Too often, families and providers wait until violence or crises erupt, and tragedies result. After such events, officials often ask, Were there ongoing "warning signs"? In most instances, the answer is "yes."

All families raising young children will encounter risky and difficult situations. To effectively address these challenges, professionals must develop comprehensive, integrated "preventative interventions" that can support and strengthen families in the face of adversity. Inherent in current federal and state legislation for EI is the mandate for collaboration across agencies and multiple disciplines—a system of care, education, and public policy that necessarily varies in terms of implementation and effectiveness. When services are integrated well, families and young children benefit. When they are fragmented, they fall short of the potential for effective mental health solutions. The latter is particularly troubling in light of the growing needs for mental health services for families and children in their earliest years. However, the efforts of today's professionals—including early intervention educators, pediatricians, social workers, those in the legal fields, and other professionals serving families and young children—will significantly contribute to achieving a comprehensive system of mental health services from which parents and caregivers can benefit.

RECOMMENDATIONS FOR PROFESSIONALS

- Seek to establish meaningful and equal partnerships with parents and caregivers, valuing what families bring to situations.
- Discover and strengthen the potentials of families, setting aside preconceived perceptions.
- Seek to understand children within the context of their families.
- In the absence of a consistent, nurturing adult, seek alternative family relatives and friends as supports for children.
- Problem solve immediate adverse situations and issues along with families, and search for positive alternatives.
- Examine their own lenses of bias as they interact with families and colleagues across disciplines and agencies different from their own; refrain from judging difference and celebrate diversity.
- Seek to engage families in preventative solutions, widening supportive networks and knowledge of accessible community resources.
- Develop a family-specific plan for service coordination.

RECOMMENDATIONS FOR PARENTS

- View challenging situations as opportunities for learning.
- Seek to create stable and safe home environments for themselves and their children.
- Seek strategies for strengthening and nurturing their relationships with their child/children.
- Understand their child's behavior as communication.
- As needed, develop age-appropriate functional behavior plans with professionals to guide children's challenging behaviors.
- As needed, learn how to appropriately play with their infants and young children.
- Acknowledge and value their own strengths and self-owned resilience.

- Be willing to adapt to challenging situations.
- Be willing to ask for help and assistance, but also assume the appropriate responsibilities of parenting their own child/children.
- Finally, despite the multiple challenges of parenting, recognize and reaffirm the many gifts and opportunities that raising their child/children brings to their lives.

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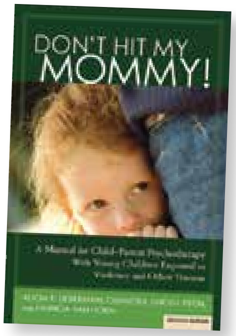
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