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SUPPORTING INFANTS, TODDLERS, AND FAMILIES IMPACTED BY CAREGIVER MENTAL HEALTH PROBLEMS, SUBSTANCE ABUSE, AND TRAUMA

A COMMUNITY ACTION GUIDE

Supporting Infants, Toddlers, and Families Impacted by Caregiver Mental Health Problems, Substance Abuse, and Trauma

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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Supporting Infants, Toddlers, and Families Impacted by Caregiver Mental Health Problems, Substance Abuse, and Trauma:

A Community Action Guide

Monica takes a seat in your office and tries to calm her 4-month-old baby, Ella. Tension masks Monica's sleep-deprived face. Last week, you met with her for the first time and helped her find better child care for her three children. She thanks you for that today. Still, she doesn't appear to be doing well, and you think she might need additional help.

Tending to three young children is reason enough to look exhausted, but you wonder if she is struggling with something else. She told you last time that she had a drinking problem when she was younger, and that her parents used to fight a lot. You wonder what her life at home is like, now that her husband is deployed overseas. Does she have any close friends or supportive people around her? Who helps her with her children if she needs a break?

You have learned through the years how important it is to support parents so they can give their children what they need. You know that how parents respond to their children has a big impact on how children feel about themselves, how they will do in school, and how competent they will feel as adults (National Scientific Council on the Developing Child, 2004c). You have learned a lot about early brain development and understand how early experiences shape the developing brain (National Scientific Council on the Developing Child, 2004a). You wonder what Monica's children are taking in from their life at home.

This information about early brain development has made you aware of how important your help can be. But sometimes it's a bit overwhelming to realize how powerful these early experiences can be for children. After all, there are limits to what you—or your agency or community group—can do.

In this *Community Action Guide*, we will follow Monica and her daughter Ella and point out resources that service providers, advocates, and practitioners might use to better understand and respond to the signals that Monica and Ella are sending. Even more important, this guide presents information, resources, and tips useful for engaging the wider community to come together for Monica and others in need of resources and support. The aim is to build a ***responsive community***: a community that has as its goal to respond as sensitively to the needs of a family as a committed caregiver does to his or her child.

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Caregivers Coping with Mental Health Problems, Substance Abuse, and Trauma

Struggling families appear every day in clinics, childcare agencies, churches, schools, and domestic violence shelters. Many more families never even reach these points of entry for help. They find themselves isolated and trying to cope on their own. Besides the difficult task of raising children—often while working full-time—many caregivers deal with added stressors such as mental health problems, substance abuse, and a history of trauma. These problems can challenge a parent's ability to be attentive to his or her children. Some very young children in these situations may have experienced or witnessed traumatic events. Sometimes their parents are unable to protect them from physical or psychological harm. For a small group of these children, parents or other caregivers cause the harm (Center on the Developing Child at Harvard University, 2007). These experiences can affect infants and toddlers in profound ways.

There are a number of ways that policymakers and practitioners can intervene to improve outcomes.

Life stressors, such as physical or sexual abuse, exposure to domestic violence within the family, witnessing community violence, and depending on parents with mental health and substance abuse problems often place the children in these families on a difficult path. These problems also tend to cluster in families: Often, if one is present, others are present as well (Knitzer and Lefkowitz, 2006). We also know that the more of these harmful experiences a child is exposed to, the more likely the child will have difficulty with social and emotional functioning in childhood, exhibit cognitive problems, fail in school, and have high levels of mental health problems and substance abuse as an adult (National Scientific Council on the Developing Child, 2004b; Gewirtz & Edelson, 2004; Heather, Finkelhor, & Ormond, 2006). Chronic health conditions (including heart disease, diabetes, cancer, and lung disease) have also been linked to adverse experiences in childhood (Felitti et al., 1998).

Experiences Affect the Young Child's Brain

Studies looking at how the brain develops in infants and toddlers (National Scientific Council on the Developing Child, 2004b, 2005) give us a better understanding of why this early exposure to very stressful situations can lead to such harmful outcomes. During the earliest years—from prenatal to age 5 years or so—the brain is most open to outside influences. Because the brain is shaped in important ways by experiences at this early age, overly stressful or traumatic experiences—such as witnessing or experiencing violence, or being raised by caregivers affected by substance abuse or mental health problems—can have a powerful impact on the young brain. These adverse experiences can even affect the basic foundation of the developing brain, contributing to problems throughout life.

But that is only half the story. Infants and toddlers are also ripe to soak up the beneficial aspects of their daily life. The young child's immediate environment—the interactions with responsive parents and other caregivers, rich sensory stimulation, and routines that shape a child's day—can actually build the brain in healthy ways. What happens in all of the tiny interactions between Ella and the world that surrounds her can help her develop a resilient, well-functioning brain. This resiliency will give her a better chance for a happy, productive life as she grows. This is one reason that support from a responsive community can have such big impacts in these earliest years—this support can positively affect the developing brain.

Protective Factors: Helping to Build Resilience

Although all families with young children need the support of the larger community, support from a responsive community is even more critical for vulnerable children and families. A literature review conducted by the Center for the Study of Social Policy identified five major protective factors (Knitzer & Lefkowitz, 2006) shown to lead to better outcomes for children, even when life has been unkind to them:

1. Concrete support in time of need;
2. The presence of a good support system;
3. The use of good parenting skills;
4. The mental health and psychological resilience of the parents or other caregivers; and
5. The child's own social-emotional and cognitive capabilities.

When present in families, these factors can make the stressful times more manageable or can help prevent some stressful situations in the first place. A responsive community can influence ***all*** of these five protective factors. We will explore how to do this in more detail in Section 3.

Creating these growth-promoting environments for children can be a challenge for any family. For parents or other close caregivers struggling with mental health problems, substance abuse, or trauma, the task can be daunting. Society still tends to blame any individual facing these problems, often judging parents or caregivers even more harshly. Even those of us who work with children and families can forget that many parents were neglected, abused, or traumatized early in life. The effects of these experiences often make it more challenging for these parents to be the kind of caregivers they want to be. For our efforts to be successful, we need to take this information into account when we structure our outreach efforts and programs (Knitzer & Lefkowitz, 2006). It is important to recognize, too, that all families have strengths. Responding to families involves addressing challenges in a supportive way, as well as recognizing and building on strengths.

The importance of focusing on the well-being of infants and toddlers, as well as their parents and other caregivers, is slowly beginning to penetrate public consciousness.

The exciting news is that, as members of a responsive community, there is much we can do to create and maintain these protective factors. The importance of focusing on the well-being of infants and toddlers, as well as their parents and other caregivers, is slowly beginning to penetrate public consciousness. We have an important role in spreading the message—that the earliest years are crucial for the health of the individual and the health of our communities—whenever and wherever we can. Not only will individual children and families benefit, so will society as a whole. Nobel Prize-winning economist James Heckman writes convincingly that investing in our infants and toddlers is the best economic investment we can make (Heckman & Masterov, 2004). In fact, he says that for every year of a child's life we delay in making these investments, we will end up spending more money on problems we could have prevented in the first place—money wasted on lost productivity, incarcerations, mental health and substance abuse treatment, and physical health problems. To be successful in helping children, this investment also needs to target the most powerful influence on a child's well-being: parents and other caregivers.

How to Use the *Community Action Guide*

We know that the problems facing families today are complex. But we've also seen that small changes can have big impacts. Working together—connecting community resources and groups—enables us all to work more efficiently to help families benefit from resources that are coordinated and responsive to their needs.

This Guide is organized in sections designed for your practical use. In **Section 1**, we focus on the importance of early development, highlighting recent findings about how the brain develops. In **Section 2**, we look at the newest and best research on how toxic stress can harm brain development. We focus particularly on toxic stress that can occur in families struggling with mental health problems, substance abuse, and a history of trauma. Use this information when you are developing or making the case for a new outreach effort, a new program, or a new law or advocacy effort.

In **Section 3**, we look at how to build a sturdy foundation for the very young children in our communities, starting by supporting interactions between children and their closest caregivers, and then expanding to a wider sphere. Here the emphasis is on building supports and coping capacities in the families and in the people and service providers surrounding the child. This section can be used as a springboard to goal-setting and planning when you've gathered community partners.

Section 4 provides you with a six-step road map for action:

1. Assess how far along your community is in building resources and structures that contribute to the well-being of families;
2. Assess your community's capacity for supporting family well-being;
3. Build partnerships and coalitions among existing community groups;
4. Outline a strategic plan;
5. Provide guides and tips for implementation; and
6. Evaluate your efforts to better understand your impact and continually improve your strategies.

Section 4 is designed to be a guide for identifying doable strategies. Although the process may seem complex, each of the steps can be used one at a time to increase your chances for success—whether you are embarking on outreach efforts or working to create larger programs or structures.

The appendices to this Guide include lists of organizational resources, warmlines/hotlines, screening tools, and tips on how to evaluate what you are doing. Throughout the Guide are examples of ideas (small and large) that have worked in other communities. We will also address advocacy efforts—because the best plan isn't going to go anywhere without supporters and resources behind it.

Common sense, experience in the field, and scientific research (National Scientific Council on the Developing Child, 2004c) all say that relationships matter—to young children, their vulnerable families, and all of us working to strengthen our communities. We hope you will use this Guide to develop the relationships with caregivers, professionals, and other members of your community to spark the ideas and action needed to improve outcomes for our vulnerable infants, toddlers, and families.

PRINCIPLES OF A RESPONSIVE COMMUNITY

1. A responsive community works to ***read and interpret the signals*** of stress in children, their parents, and other caregivers. These signals might be very different from family to family depending on the upbringing of the family members, their background culture, and their past experiences with service providers or community groups.

2. A responsive community understands that the ***earlier you respond to these signals, the better the outcome*** will likely be.

3. A responsive community tries to ***prevent stress in families by changing situations*** that are potentially harmful to children, and by thoughtfully creating conditions that support healthy functioning.

4. In a responsive community, providers, policymakers and community members know that ***relationships matter***: A baby or toddler needs a healthy relationship with at least one adult. In the same way, each family needs a network of healthy relationships with family, friends, neighbors, childcare providers, teachers, and other members of the community. Community efforts should focus on building this supportive network.

5. A responsive community sets up resources that ***meet the family where it is*** whenever possible. Coordinated services—with supports for children and their caregivers at one site—make it more likely that a family will be able to access the services they need.

6. A responsive community realizes that ***one size does not fit all.*** Whenever possible, services and supports should be designed to be as flexible as possible to ensure that they address each family's particular needs.

7. A responsive community ***works together and builds partnerships*** to create a thoughtful plan to address the needs of children and their families. Relationships matter—not only for children and caregivers but also for our work with them.

8. Although partnerships and coalitions are useful, being a member of a responsive community also means ***asking yourself first: What can I do?*** In my role as a service provider, advocate, administrator, or law enforcement officer, what can I do to address the needs of the young children and families that I meet? Sometimes a committee is not needed—sometimes all they need is you.

9. A responsive community works with the understanding that family members struggling with mental illness, substance abuse, or trauma have experienced significant stresses throughout their lives and may not always have had necessary supports. Being genuinely cared about, listened to, and responded to can powerfully support a family to make positive changes. ***Little things can make a difference, if they are based on respect.***

10. Often we see families during their most difficult times, but a responsive community recognizes that ***each family has strengths***. Each family's story has within it signs of how they have struggled to meet the challenges that face them. You can help rebuild hope by uncovering and acknowledging these strengths.

SECTION 1:

WHAT'S SO IMPORTANT ABOUT BIRTH TO 5?

What happens during the first months and years of life matters a lot; not because this period of life provides an indelible blueprint for adult well-being, but because it sets either a sturdy or fragile foundation for what follows.
—National Research Council and Institute of Medicine (2000)[1]

Think of all the amazing lessons that a child learns in the first years of life. Between birth and age 5, Ella, the 4-month-old in the opening vignette, will learn to crawl, stand, walk, and run. She may learn her colors, her numbers, and her ABCs. Besides these obvious skills, baby Ella is learning much more. When she smiles or coos, she will learn if anyone will respond to her by matching her smiles and sounds. By being fed, bathed, diapered, dressed, and helped to sleep, she will learn that the world around her is predictable and safe. When she cries or is frustrated, she will learn if she can depend on others to soothe her. In these early years, she will be learning lessons that will follow her throughout her life, including whether she feels loved and cared for or whether she can't rely on others to help her when she needs it.

Ella will learn and grow and change throughout her life. But these early lessons likely will have a big impact on everything that comes after. What makes these years so influential is the powerful effect of these earliest experiences on her developing brain. We now understand much more about this topic than we did a few decades ago. Up until 1985, there were only 10 articles on "brain development" in the research literature on early childhood. As of 2010, there are more than 1,000 books and articles on this topic, with new ones added daily. Similarly, "emotional development" was the topic of 161 articles until 1985; now there are more than 1,500 articles, and we are learning more about a young child's emotional development every day. People working in the field of early childhood often talk about the "explosion" of new information about infant and toddler development. These statistics testify that this is not an exaggeration.

We now know a lot more about the types of positive experiences that go into building an emotionally healthy child, a child who feels loved, who wants to learn, and who feels able to face life's daily challenges. Children are born ready to form relationships with those around them and are eager to learn. The capacity for this well-being is built into the child's developing brain. And it is shaped and strengthened by countless

exchanges between the child and the people who surround her (National Scientific Council on the Developing Child, 2004a). In order to build a sturdy, resilient foundation for our children, our families, and our communities, we need to pay special attention to what children experience during these crucial early years.

How Early Experiences Shape the Developing Brain

Like every newborn's brain, Ella's brain has a remarkable capacity for growth and change. This development is most profound from birth to age 5 or so and is particularly rapid in these first few years. The growth in the physical size of the brain during these years provides a stark illustration of this development. While a newborn's brain is about one-quarter the size of an adult's, it grows to about 80 percent by age 3, and 90 percent by age 5 (ZERO TO THREE, 2011a). There are equally impressive changes in brain structures and functioning during this time. At birth, only the lower portions of the nervous system—the spinal cord and brain stem—are very well developed. These areas control the functions that we need to survive—breathing, heartbeat, circulation, sleeping, sucking, and swallowing. Newborns also have skills to help them develop connections with their caregivers. At birth, they are able to distinguish their mother's smell and the sound of her voice from that of others, to participate in some self-soothing behaviors, and to respond to the expressions on human faces.

The higher systems in a newborn's brain—the cerebral cortex and limbic system—are the least developed at birth. The outside world has the most impact on these parts of the brain. The cerebral cortex—the "thinking brain"—controls our ability to perceive differences and similarities, to reason, and to use language. It is these thinking functions that most people probably associate with "the brain." But just as important is the limbic system, or the "emotional brain." The limbic system registers when we are happy, sad, frustrated, or angry. It also helps us slowly gain control over our emotional responses (Powers, 2008). This area of the brain is responsible for infants' growing ability to soothe themselves when upset and toddlers' beginning attempts to delay gratification.

Emotional Development Is Just as Important as Cognitive Development

The importance of the first years of life for developing the "thinking brain" of young children has received a lot of media attention in the past decade. Although this cognitive development is obviously important, so is the development of the "emotional brain." In order for Ella to face both the everyday experiences and the more stressful ones that are common in all children's lives, the "thinking system" and the "emotional system" need to be able to work together (Bell & Wolfe, 2007). This interplay between thinking and feeling is essential for a growing child who is learning how to control emotions and solve problems.

Popular media and savvy marketers have overemphasized products that try to teach babies rote facts in an attempt to "make babies smarter." This is not what Ella and other babies need for healthy brain development. Instead, what strengthens connections in the thinking and emotional centers of a baby's brain is a consistent and nurturing relationship with one or a small number of caregivers, coupled with sensory stimulation that comes from exploration and play. A responsive community can take steps to ensure that high-quality, user-friendly information about what children really need for healthy development is available to parents and other caregivers, childcare workers, child advocates, health care workers, faith groups, and other interested community groups. It can also work to ensure that supports are in place to enable families to be consistent, responsive caregivers for their children.

INSIDE THE BRAIN

The brain is made up of many areas that are in charge of specific functions, such as identifying what we see, processing language, storing memories, and assessing whether or not we are in danger. Within each of these brain areas are neurons, or nerve cells, which send messages to each other across synapses. New synapses between cells are constantly being formed by everyday sensory experiences that register on the brain—including what the child sees, hears, touches, and smells. Other, unused synapses are broken or pruned away. This signaling between nerve cells creates pathways that make up the "wiring" of the brain. These pathways ensure that the different brain areas can communicate and function together in a coordinated way.

The young baby's brain is genetically programmed to produce many more synapses than it will ever use. In fact, 8 months after birth a baby will have an astounding 1,000 trillion synapses in his brain. Repeated experiences strengthen certain synapses while pruning away those that aren't used. In this way, the infant's brain is being shaped by outside experiences. Although this shaping continues throughout life, it is particularly influential during the first few years, when the basic structures of the brain are developing. Experiences that are sensory rich will help the baby's brain develop in a healthy way, while experiences that provide little sensory stimulation, or are overstimulating, can affect brain development in a negative way. Experiences that are extremely stressful can be particularly damaging to the young child's brain development.

Source: Adapted from Hawley (2000).

Building Resilience Through Quality Experiences and Routines

After Ella's birth, the sights and sounds of the immediate environment outside the womb become "food" for her brain. Her rapidly developing brain registers her everyday experiences, both good and bad. Parents and other caregivers act as gatekeepers to this wider world, whether they are aware of this role or not. The physical space the child lives in, the activities she is a part of, the situations she experiences—the young child is dependent on the parent or other caregiver for all of these. This wider world can be full of opportunities to learn.

Ideally, Ella will be encouraged to explore the shapes, colors, and textures that surround her. For healthy brain development, these experiences should be sensory rich but not overly stimulating. Infants playing peek-a-boo, toddlers seeing how many pillows they can pile before they topple over or making "vrrooooom" sounds as they push trucks around the kitchen—a child playing is a child who is building a strong, efficient brain.

How does this information help parents? Those working with parents of young children can encourage them to have active, engaging types of play experiences with their children or to allow the children to explore their environment in a safe way.

Having routines has also been shown to be beneficial to a young child's well-being (Fiese, 2000). These routines should not be rigid, but they should provide enough structure so that life is predictable and feels secure. The sense of order that routines bring helps children to develop self-control, which is an important part of early development. Routines also help reduce power struggles while teaching positive, responsible behavior—"Ella, we hold hands every time we cross the street because Mommy wants you to be safe." Although establishing a sense

of routine may be difficult for adults who themselves have often grown up in chaotic households, order and structure often feel comforting to the adult as well as to the child. Children are also helped when caregivers talk about the order of these routines. Studies show that toddlers in families that use simple sequencing phrases—"first we're going to eat breakfast, then we're going to go outside"—grow up with a better sense of how events are ordered in time, a skill that helps them when they enter school (Norton, 1993).

Responsive communities can do a lot to add enriched experiences for babies and toddlers throughout the community. Some communities already offer these activities: story time at libraries, colorful playscapes, and free performances for young children. But many communities do not have these activities. You can use the information from the brochures, publications, and videos listed in the Action Steps in each Section of this Guide, and the resources listed in Appendix A to help you make a case for developing these activities in your community. Even when these resources are available, parents struggling with substance abuse, sadness or worry, and feelings of isolation are not as likely to use these resources as parents from other families. For ideas on how to reach out to families who may feel too overwhelmed to participate, the Office of Head Start's Early Childhood Learning and Knowledge Center presents materials developed by the Family Connections Project at Boston Children's Hospital (go to Family Connections Materials: A Comprehensive Approach in Dealing with Parental Depression and Related Adversities at http://eclkc.ohs.acf.hhs.gov and search for "family connections materials").

ACTION STEPS:

- Spread the word about how crucial these early years are for brain development. Emphasize that it's not just thinking skills that are developing but also emotional skills—and both are critical for the child's well-being and later success in school. ZERO TO THREE (http://www.zerotothree.org) and The Ounce of Prevention Fund (http://www.ounceofprevention.org) offer brochures and fact sheets that can be downloaded. More detailed information on brain development can be found at the Center on the Developing Child Web site at http://developingchild.harvard.edu, and from the National Center for Children in Poverty at http://www.nccp.org/publications/pdf/text_669.pdf.

- Connect childcare centers with training opportunities that highlight the importance of early experiences that are sensory rich, use routines effectively, and promote strong caregiver–child attachments.

- Spread the word about the importance of routines for children by downloading the ZERO TO THREE tip sheet, "Love, Learning, and Routines," at http://www.zerotothree.org/site/PageServer?pagename=ter_key social_routines, and distributing it at day care centers, elementary schools, clinics, and religious institutions. You can also ask if these organizations would reprint the information as part of newsletters or announcements they send home to parents.

- Set up play times for young children and their families on weekends at local community centers, churches, synagogues, and mosques—anywhere you can find donated space. Bring toys collected from community members. Ask community volunteers to facilitate (or host). Advertise play times at day care centers, grocery stores, schools, and clinics—anywhere you might find young families.

Building Resilience through Attentive Caregiving

The newborn Ella needs one or a small number of consistent, attentive caregivers to be there for her. When she cries, she needs to be picked up and soothed. When she is tired, she needs to be held, calmed, and readied for sleep. When she is hungry, she needs to be fed. These warm, caring responses help Ella develop a sense of trust and a positive self-image—that she is worthy of care, and that she can influence those around her to meet her needs. The neural pathways in her brain are also stimulated by sensory experiences, such as her mother cuddling her, her older brother singing to her, or the soft touch of a favorite blanket wrapping her securely. These not only are pleasing to Ella but also actually grow the connections between the cells in her brain.

What if these positive experiences do not occur consistently, or at all? Unresponsive or physically abusive experiences also have an effect on the neural pathways in the brain. If no one comforts Ella when she is upset, her body is flooded with stress hormones that interrupt the healthy growth of these connections. If these experiences are repeated, the actual structure of her brain will change (Shonkoff, Boyce, & McEwen, 2009). In addition to the direct effects on her brain, if she doesn't get the response she needs from her caregivers, she will likely learn that there is little she can do to get what she needs from the people around her. And because young children understand so little about the world at this age, she is not going to realize that it is because her mother is depressed, or drinking. Instead, she is more likely to feel that she is not worthy of being held or comforted or nurtured. In Section 2, we will look more closely at the effects of this ***toxic stress*** on the developing brain.

WHAT ALL CHILDREN NEED: THE FIVE R's

Relationships that are safe, secure, and loving—these help the child feel cared for and worthy of love.

Responsive interactions that allow the child to initiate a sound, a task, a game—and get a positive response from an adult. These help children learn that what they do has an impact on the world around them.

Respect for the child, and for the child's family and culture. Treating the child as an individual with rights and feelings goes a long way toward establishing feelings of self-esteem.

Routines provide comfort for the child, allowing him to predict what will come next during the day. They also encourage memory and the development of early organizational skills.

Repetition of activities actually strengthens the connections between brain cells. While adults usually tire of repetition, children are drawn to repeat activities and tasks over and over again in an attempt to master them.

Source: Adapted from Seibel, Britt, Gillespie, and Parlakian (2006).

Like all infants, Ella prefers human interaction over everything else. Studies show that babies naturally orient to people's faces and would rather listen to speech or singing than any other kind of sound (Papousek, 2002). These are innate responses shown by all typically developing infants. And adults have an equally strong urge to respond to infants—they often act nurturing or playful even with unfamiliar babies. The kind of behavior that adults show toward young children—touching, holding, rocking, singing, and comforting— are pleasurable to many adults (Hawley, 2000). In fact, a recent study found that when mothers look at their

baby's smiling face, the mother's brain releases dopamine, which is a pleasure hormone (Strathearn, Li, Fonagy, & Montague, 2008). Feeling pleasure at the baby's smile encourages the mother to gaze longer at her baby's smiling face. This attentiveness makes the baby want to smile even more. This exchange of gaze and smile builds a positive connection that both the baby and the mother enjoy.

Most cultures around the world see childrearing as more than something that happens between a mother and her child.

But what about a caregiver who seems to find no pleasure in caring for her infant? This may be a sign that she needs additional help. It could be a sign of postpartum depression (Gjerdingen, Crow, McGovern, Miner, & Center, 2009), addiction to substances (Mayes, Magidson, Lejuez, & Nicholls, 2009; Swain, Lorberbaum, Kose, & Strathearn, 2007), or stress that is overwhelming to the caregiver (Salisbury, Yanni, LaGrasse, & Lester, 2005). It could also be due to characteristics of the infant: a special need or developmental delay that makes the infant less interactive with the parent. A responsive community can have a big impact on a family's future by ensuring that all new mothers are screened for mental health and substance abuse problems, and that newborns and infants get early developmental screenings. Those needing help for mental health, substance abuse, or developmental issues should be connected to needed services and supports. These threats to attentive caregiving—including the caregiver's depression, substance abuse, trauma, and a lack of social supports—will be explored in Section 2.

A Community of Caregivers

While Ella needs at least one primary caregiver to depend on, other people besides her mother or father—grandparents, childcare providers, aunts, neighbors, even older siblings and cousins—who have Ella's best interests at heart can also play a big role in her development (Howes, 1999). Though psychologists in the United States have focused on the importance of the primary caregiver, usually the mother, there is theory and clinical evidence to suggest that having a few close attachment relationships helps a baby or toddler be more resilient (Bowlby, 2007). The key is that the child feels safe and secure with each of these people, and that they are a consistent presence in the child's life.

While young children are better off with more than one attentive caregiver in their lives, they do tend to prefer one person over another—or develop what is called a "primary attachment relationship." This is clear when they are hurt or frightened; they tend to cling to the person who makes them feel the most secure. If this person is not present, they will turn to the next person they feel this way about. When you ask Monica, she tells you that Ella's uncle can also calm her when she's crying. Because many young children of working mothers spend regular time in the care of nonrelatives, it's also important to know that, if given a chance, children can develop secure relationships with a childcare provider or adults who are not a part of the family (Mardell, 1992).

In fact, most cultures around the world see childrearing as more than something that happens between a mother and her child. This model of childrearing, with important child–caregiver relationships extending beyond the mother–child or even mother–father–child bond, is also common in immigrant groups and communities of color in the United States (Mchale, 2007; Lamb, 2005). At times, the emphasis on one primary caregiver in European-American culture in the United States has blinded professionals to the richness of this model of extended family caregiving. The responsive community finds ways to celebrate and strengthen these networks of extended families and friends caring for young children.

PREVENTING MULTIPLE PLACEMENTS IN FOSTER CARE

Moving young children from foster home to foster home is a common practice. There is an entire category of foster homes that serve as emergency placements for the first few days after a child is removed. The expectation is that the child will be moved into another home where he or she can stay until it is determined whether the parents can regain custody. Terminating parents' custodial rights often leads to another change in placement: from a foster to an adoptive home. Because young children need a stable connection to their caregivers, repeated changes in those caregivers can be very harmful to babies, toddlers, and preschoolers. Multiple changes in caregivers can cause depression, anxiety, grief reactions, and other emotional changes that interfere with daily functioning.

Recently, child welfare agencies have sought to place young children in the care of extended family members, which has led to fewer placement changes. Other innovative approaches, such as Family Group Decision Making, encourage the involvement of parents, extended family, and other concerned people in the child's network to join together to develop a safety plan for the child, including a plan for the child's everyday care. This safety plan is then presented to professional child protection workers, who give their feedback. In this way, the child's social network is encouraged to become more involved in the child's future. One result is that children are less likely to be placed with unfamiliar adults (American Humane Association, 2000; Harper, Pennell, & Weil, 2002). For more information on Family Group Decision Making and other similar models of child protection planning, see the Annie E. Casey Foundation's "Family Teaming" at http://www.caseyfamilyservices.org/userfiles/pdf/teaming-comparing-approaches-2009.pdf.

Source: Adapted from Cohen, J. (2009).

In Section 2, we will look more closely at threats to resilience. Although we focus on specific experiences that can threaten a child's well-being, remember that the earliest years are also full of opportunities for young children. Communities play a central role in providing these positive opportunities. When we include the most vulnerable children in our vision of a healthy, happy community, the whole community is strengthened. You can take pride in being a part of building this strong foundation in your community.

SECTION 2:

THREATS TO RESILIENCE

How is it that some children live through adversity and yet are able to return to healthy functioning, while others are not? Psychologists used to concentrate on characteristics of the child (intelligence, temperament) to explain why some children seemed more resilient than others (Masten, Best, & Garmezy, 1990). These are part of the picture. But for infants and toddlers, more recent studies have found that having an attentive caregiver (Gunnar & Donzella, 2002; Schuder & Lyons-Ruth, 2004) and a wider community of caring (Kasmin, 2009) are more important. This makes sense, because young children are so dependent on the people around them.

Monica herself grew up in a family of hardship. When the economy was thriving, her father found work. When it was not, he was often jobless—and often felt demoralized and angry. He would take out his shame at not being able to find work on his family. Monica's mother drank, and her father hit her mother sometimes. Her mother yelled at her father that if he ever hit Monica she would leave him. Monica knew that her mother was trying to protect her, but she also felt like this wasn't enough. When Monica was a teenager, her father left them. Even though he was no longer in the house, Monica often felt frightened and worried.

Adults have long realized that children are vulnerable to physical harm. But in the past, most believed that young children were "too little to remember" difficult early experiences. The fact that they couldn't talk about their distress was thought to mean that they were not affected by it. Unlike older children or adults, young children were expected to "get over it." In this sense, all young children were thought to be resilient. Experience with children and families tells us otherwise—and this is backed up by numerous studies. In fact, of all age groups, infants and toddlers are the most vulnerable to the destructive impact of severe stress. Being unable to understand or communicate what has happened makes an early stress or trauma even more difficult to manage. Overwhelming and chronic stress can have harmful and long-lasting effects on a child's emotions and behaviors.

In fact, we now understand that, because adverse experiences impact the developing brain, even experiences the child doesn't consciously remember can have lifelong effects. This is why it is important to assess the impact of stressful experiences and trauma on young children, and to provide supportive care for them.

Maternal Stress and Substance Abuse in Pregnancy

Before birth, Ella's world was the womb. For the brain of the fetus to develop properly, Monica needed adequate nutrition and needed to avoid alcohol, drugs, and environmental toxins (National Scientific Council on the Developing Child, 2005, 2006). In addition to these physical inputs, studies have found that if the mother is depressed or under extreme stress, this too can have negative effects on the developing brain of the fetus (Salisbury et al., 2005; Ruiz & Avant, 2005). In this prenatal period, screening and offering services for nutritional deficits, substance abuse problems, the presence of family violence, and mental health issues is the first line of

protection for both mother and fetus.

Abuse of alcohol poses a severe threat to the developing fetus, and alcohol is more commonly used than illegal substances. In one study, 23 percent of pregnant women drank alcohol while pregnant, while 6 percent used marijuana and 5 percent used methamphetamine (Arria, et al., 2006). Babies exposed prenatally to alcohol can suffer from fetal alcohol spectrum disorder (FASD). FASD is an umbrella term used to describe a range of harmful effects of prenatal alcohol exposure on the fetal brain. These effects can lead to lifelong learning disabilities, attention deficits, hyperactivity, poor impulse control, and social, language, and memory deficits. FASD is a leading known cause of mental retardation and is estimated to occur in 1 percent of all U.S. births, or nearly 40,000 newborns each year. The cost to the nation of caring for children and adults affected by fetal alcohol syndrome (FAS)—the most severe form of FASD—is estimated to be up to $6 billion each year. For one individual with FAS, the lifetime cost is at least $2 million.

The number of expectant mothers seeking treatment for methamphetamine abuse tripled from 1994 to 2006.

Methamphetamine use among pregnant women is also a significant health problem. The number of expectant mothers seeking treatment for methamphetamine abuse tripled from 1994 to 2006. In 1994, methamphetamine use accounted for 8 percent of all admissions to federally funded drug treatment centers for pregnant women, but by 2006 that number was 24 percent (Terplan et al., 2009). Evidence is mounting that the use of this stimulant while pregnant also has long-term effects on the child's brain. One study used brain imaging techniques with 11-year-old children who had been exposed to methamphetamine in the womb. It found that two structures in the brain—one that is important for learning and memory, motor control, and punishment and reward, and another that helps a child with control and conflict resolution skills—were abnormally small or misshapen (Sowell et al., 2010). Other studies found that newborns whose mothers used methamphetamine during pregnancy are 3.5 times more likely to be born underweight compared to newborns whose mothers didn't use the drug.

Perhaps the most important statistic to know, however, is that exposure to alcohol and methamphetamine is 100-percent preventable: If a woman does not use during pregnancy, her child will not be affected (Fetal Alcohol Spectrum Disorders Center for Excellence, 2010). A responsive community can have a big impact on a child's life by educating the community about this risk and by providing needed treatment and support to expectant mothers who wish to stop using alcohol and illegal substances.

ACTION STEPS:

- Launch a community campaign against FASD using resources available through the Substance Abuse and Mental Health Services Administration (SAMHSA) Web site, http://www.fasdcenter.samhsa.gov/grabGo/grabGo.cfm. Here you will find a "Grab and Go" feature with camera-ready documents and a PowerPoint presentation that you can use to inform community members of this risk. Distribute the flyers at PTA meetings, health fairs, and doctors' offices. Plan presentations using the downloadable PowerPoint slides prepared by SAMHSA.

- Inform health care workers about the relationship between maternal trauma and excessive drinking in pregnancy. In one study of 186 mothers who gave birth to infants with FASD, all but 10 were survivors

of sexual abuse, and there were equally high rates of mental health disorders, primarily depression and Post-Traumatic Stress Disorder (PTSD). Referrals to mental health professionals should be made for expectant mothers who are found to be using alcohol. Groups such as Alcoholics Anonymous can also be helpful. Because half of all pregnancies in the United States are unplanned, primary care physicians should use screening tools, such as T-ACE and the TWEAK (see Appendix B), with all women of childbearing age. T-ACE is a four question test (tolerance, annoyed, cut down, and eye-opener) valuable for identifying a range of use including lifetime use and prenatal use. TWEAK is a five-item scale and an acronym for Tolerance, Worried, Eye-opener, Amnesia, and K/Cut down (cutting down on alcohol consumption).

- Partner with a Healthy Start initiative in your State to provide services for pregnant women, including help with nutrition, prenatal visits, and referrals to programs known to help women avoid drug use while pregnant. See the National Healthy Start Web site at http://www.healthystartassoc.org for more information.

- Collect information on programs to reduce alcohol and drug abuse that have been evaluated and found successful. These evidence-based programs can be found at the SAMHSA Web site at http://nrepp.samhsa.gov/find.asp.

STRESSFUL EXPERIENCES AFFECT INFANTS AND TODDLERS

As baby Ella grows, her life, like all young children's, is a mix of the familiar and the new. She takes comfort in the familiar faces and sounds of her family. Daily routines calm her. If her favorite snuggy is missing, she is distraught. But she likes novelty, too. As she begins to crawl and then walk, new experiences begin to outweigh the familiar. Her curiosity propels her to explore her world—which helps strengthen her developing brain.

When Ella is challenged by situations that threaten her, like a barking dog right outside her window, her brain will register the dog as a threat. Her heart will pound, and her blood pressure will increase. In her brain, the stress hormones cortisol and adrenaline will be released. These changes in the body happen automatically. They help the body get ready to act—in this case, to reach for an adult, or to crouch protectively. They sharpen the senses and give the body more energy to do what it needs to do. When an adult removes Ella from the situation, or reassures her that she is safe, her body stops producing stress hormones, and

The following chart illustrates the types of stress reactions infants and toddlers may experience and their impact on the brain.

TYPES OF STRESS		
Type of stress	***Example***	***What happens in the brain***
Positive stress occurs when a child confronts a challenging situation, but he is able to handle it on his own, or he has guidance from an adult	A 1-year-old successfully calms himself at naptime; a shy 3-year-old on the first day of child care is made to feel welcome by the childcare worker; a 5-year-old successfully climbs a tree	The brain releases a short burst of the stress hormone cortisol, but managing the challenge makes the stress response a short one; this is beneficial for the brain over time—it increases the brain's capacity to self-regulate
Tolerable stress can occur in the face of a more serious threat, if there is a consistent, responsive adult to help the child adapt and feel safe	A loss of a loved one, a natural disaster, a frightening injury or hospitalization—with the help of an adult who can respond to the child's physical and emotional needs	If the adult makes the child feel relatively secure and comforted, cortisol levels will return to baseline, with no long-term harm to the brain
Toxic stress can occur when there is a strong, frequent, or prolonged exposure to an adverse experience and there is no adult available who will support or comfort the child	Physical or sexual abuse, physical or emotional neglect, extreme poverty, severe caregiver depression, or any of the examples listed in tolerable stress if there is no supportive adult available	These situations can create unusually high levels of cortisol for long periods of time. This can disrupt developing circuits in the brain, leading to depression, anxiety, PTSD; behavioral and learning difficulties, and health problems in adulthood
Traumatic stress is an extreme form of toxic stress, and occurs in response to an event or series of events that threaten serious injury or death to the child or others	Traumatic stress occurs in response to physical or sexual abuse, domestic violence, intrusive medical procedures, and life-endangering accidents such as near drowning	High levels of cortisol for long periods of time can disrupt developing circuits in the brain, leading to depression, anxiety, PTSD, behavioral and learning difficulties, and health problems in adulthood.

Source: Created using content from National Scientific Council on the Developing Child (2005), in consultation with Alicia Lieberman, Ph.D., Irving B. Harris Endowed Chair in Infant Mental Health, Department of Psychiatry, University of San Francisco.

Positive Stress

A number of situations can create a mild stress response. When 2-year-old Ella gets frustrated trying to climb a steep step, her brain may release small amounts of cortisol. Situations like these are challenges to a child, and cortisol helps the child focus to meet these challenges. If the situation is manageable—Ella figures out how to climb on her own, or Monica is nearby and guides her—then the stress response doesn't last very long. Her cortisol level goes back to baseline. This type of stress response is called ***positive stress*** (National Scientific Council on the Developing Child, 2005) because when the child learns how to respond to a stressful situation in a competent way, the brain actually becomes more resilient.

Positive stress is a healthy part of normal development. Over time, thousands of these everyday situations help Ella gradually gain control over her emotions and, eventually, her behavior. Psychologists call this the capacity to self-regulate (Masten & Coatsworth, 1998). This growing capacity for self-regulation is central to early development. When Ella is able to self-regulate, she is better able to focus on the objects, people, or situations that she needs to, while blocking out unimportant things that are going on at the same time. Successful self-regulation also allows older toddlers and preschoolers to calm themselves down when they are upset (self-soothe), wait their turn in line (delay gratification), focus on tasks, and be less reactive to new situations. Biology and temperament also play a role here: Some children seem to be more emotionally reactive from birth, while others are calmer. But what happens after birth also has a big impact on how well a child's brain self-regulates, as we shall see.

Tolerable Stress

If we think of positive stress as occurring when the child is confronted with everyday challenges that can be overcome—with or without the help of others—it is easier to see why this type of stress can actually be growth-promoting for the child. Over time, the experiences that lead to positive stress, and the stress response itself, help a child become more capable of responding to challenges that are more and more difficult.

But what about experiences that are threatening to the child and impossible for a young child to manage on his own? These experiences often trigger a stronger and longer lasting stress response in a young child's brain. Examples include the loss or separation from a loved one, the hospitalization of the child or the caregiver, or experiencing a natural disaster like a flood or a fire. For both children and adults, the brain goes on high alert in these situations. And young children tend to be more vulnerable than adults because their brains have not yet learned how to regulate the stress response. Because of this, their high-alert state can last longer than the typical adult's. Too much time in high alert can actually shape the structure and wiring in the young child's brain, making it more and more difficult for the brain to return to a calm state (Perry, Pollard, Blakley, Baker, & Vigilante, 1995).

The good news from recent brain research is that a lot can be done to help reduce the risk of the harmful effects of stress for children in these situations. The response of parents and caregivers is often the key to how these experiences affect the child. Studies have found that when a caregiver or other adult comforts the child or takes other actions to keep the child from feeling overwhelmed, the stress response system can calm down (Center on the Developing Child at Harvard University, 2007). Just the physical presence of a trusted and caring adult can help lower cortisol levels (Gunnar, 2005; Schore, 2001). Positive

physical touch is particularly helpful in reducing stress levels (Field, 1995). These types of adult inputs help determine how long the stress response lasts. If the child's stress response system can be calmed, there may be no lasting harmful effects of stress on the child's body and brain. For this reason, this type of stress is called ***tolerable stress***. Like positive stress, tolerable stress can actually help build later resilience to stressful situations by helping to calibrate a child's stress-response system (Shonkoff, 2008).

But keeping stress within tolerable limits may be difficult for caregivers who are also in the middle of a crisis situation. The more caregivers have had a chance to develop their own coping skills before a crisis hits, the more they will be able to keep their own stress within tolerable limits so they can respond to their child in need. But coping is often compromised for adults struggling with mental health and substance abuse issues. Targeting families during these crisis situations, and giving them support, can have a big impact. Helping the parent or caregiver manage the situation can keep stress within tolerable limits, for both the adult and the child.

In addition to helping adults manage their own stress, in some situations a responsive community can offer the child a "zone of safety" (Perry et al., 1995)—the presence of another adult who is aware of the importance of responding to the child's need for protection and soothing. This can be a neighbor, relative, or childcare provider with a connection to the child, or trusted adults who offer the family respite care. These people are not always available in the family's life, but when they are, they should be encouraged to give at least as much attention to the child in a crisis situation as they do to the distressed adult. In this way, community support and assistance can prevent extreme stress from harming the young child's developing brain.

ACTION STEPS:

- **Support the family with concrete services if the stressful event has disrupted their housing, employment, and daily routines. Simple acts like bringing food to a family in need is a concrete way to help but also can go a long way in making families feel supported and less isolated.**

- **Encourage caregivers to pay special attention to the child during challenging times and crises. Strategies for caregivers include holding and comforting the child. "Clingy" behavior means that the child is stressed and needs to be comforted. Even if children show no visible signs of stress, they may be affected.**

- **Reach out and comfort the child in these situations, if it seems appropriate. If you have a good relationship with the child, use it to help them in difficult times. Remember, just the presence of a calm, trusted adult can help calm the child.**

- Find support groups for adults undergoing stresses, such as loss through death or partner breakup. Set one up if there is no support group in the community. Remember that couples do not have to be married for a breakup to be experienced as a major loss.

- Set up a network of brief respite care for children when the caregiver is experiencing extreme stress and does not have friends or family available to help with her children. Detailed descriptions of two programs that highlight respite care along with other services can be found on the Web: the Strong Communities for Children program at http://www.dukeendowment.org/issues/children/child-abuse-overview/strategy and Safe Families for Children through LYDIA Home Association at http://www.lydiahome.org.

- Encourage families to get help from familiar sources of support, including extended family, religious leaders, and faith or community groups.

- Provide a list of mental health professionals available for families who may want additional help. Professional assistance can make a real difference in keeping stress within tolerable levels.

Many of the protective factors for caregivers listed in Section 3 (helping caregivers to develop a support system, practice effective parenting skills, and address their own mental health needs) are long-term strategies that will help caregivers cope more effectively when they are confronted with crises or difficult times. Kate's Club in Atlanta, GA, is an organization that helps children grieve the loss of a parent or sibling. This timely support in a time of crisis can help prevent future emotional and behavior problems in children who have suffered a tragic loss: http://www.katesclub.org/aboutus.htm.

KATE'S CLUB

Kate's Club in Atlanta, GA encourages children and teens to grieve the loss of their family member, and to face their new life with confidence and hope. On Saturdays at Kate's Club, the emphasis is on fun activities and interaction with other members of the Club. This helps children laugh, play, and understand that there are others their age who have faced a loss. Saturday activities include sharing circles, "Griefstyles" coping sessions, arts and crafts, games, and special guests.

Kate's Club also offers grief support groups, which are age specific. With the help of professional therapists, children learn to express their emotions through music, movement, and drawing. Other support services are offered to bring a child and his family together with other families to celebrate the life of their loved one. For more information on Kate's Club, see http://www.katesclub.org.

Toxic Stress

The third type of stress response is called ***toxic stress***. Toxic stress is a strong, frequent, or prolonged activation of the body's stress response system. In situations of toxic stress, the brain is on high alert and stress hormones are flooding the brain and body. This activation of the stress response system lasts longer than is healthy and can actually damage developing circuits in the brain. Stressful events that are severe and uncontrollable, without the child having access to caring adults, tend to provoke toxic stress responses. Many of the situations listed above in the section on tolerable stress can cause toxic stress if the child receives little or no help from parents, other caregivers, or the surrounding community. Young children in these situations of toxic stress are at higher risk of developing symptoms of anxiety and depression than are other children (National Scientific Council on the Developing Child, 2005).

Traumatic stress is a particularly severe form of toxic stress. While this type of stress can occur as a result of a horrific one-time event, it is more likely to result when the child is subjected to a series of disturbing events that occur over time. Traumatic events (also called "trauma") are so severe and threatening that a child is afraid of injury or death or otherwise feels deeply threatened (National Scientific Council on the Developing Child, 2005). In some cases, traumatic stress is due to accidents (a child who nearly drowns or survives a fire or car accident), while at other times it is due to abuse at the hands of others or to witnessing violence (either in the home or in the neighborhood). In addition to anxiety and depression, children subjected to potentially traumatic situations can develop post-traumatic stress disorder, or PTSD. Although it was once thought that children were not affected by the disorder, post-traumatic stress symptoms have been found to occur in infants, toddlers, and pre-school aged children (Lieberman, 2007).

When Toxic Stress Becomes Traumatic: Violence in Families

Violence that occurs in the home—for example, a parent physically or sexually abusing the child, or the child witnessing domestic violence—is the most common source of traumatic stress for young children. In these situations, not only is the child's physical safety threatened, but because the child often no longer has access to a caregiver who protects her from the event, the child's feelings of emotional safety can also be damaged (National Scientific Council on the Developing Child, 2005).

In the examples of the physical abuse of a young child, the child's mental state typically moves from calm to arousal, to alarm, to fear and then to terror. This alarm reaction to extreme threat can be adaptive for an adult—it leads to the "fight or flight" behavior that can increase the odds of survival in life-threatening situations. Young children, however, cannot fight or flee. Instead a child will typically call or cry out to get a caregiver's attention. This is a signal for a caregiver to come and protect the threatened child. In a sense, it is a call for the caregiver to come and fight or flee on the child's behalf (Perry et al., 1995). But when the caregiver is either unresponsive to the child or is the cause of the threat in the first place, the child is left feeling particularly helpless and without protection.

Without this protection, the child will typically become more agitated, and her cries will turn into screams. Heart rate, blood pressure, and respiration increase. Cortisol and other stress hormones begin flooding the child's brain and body. If the threatening situation is repeated, which is often the case in situations of family violence, brain circuits and biological systems are affected. The more often the young child's brain is subjected to this traumatic stress, the more likely the actual architecture of the brain will be changed. Young children do

not have to be a victim of violence to experience traumatic stress. Witnessing domestic violence (also called "intimate partner violence" or IPV) can trigger a similar stress response in the brain. IPV may be committed by same-sex partners as well as by women against men. However, most studies on the effects of IPV look at children in homes in which a male partner commits violence against the child's mother. Often, physical violence is only part of a larger climate of emotional abuse that includes threatening and intimidating behavior. It is not unusual for children living in homes in which violence and threats are used to control behavior to develop feelings of inadequacy, powerlessness, and helplessness (Graham-Bermann, 2002). In many situations of domestic violence, the children's mother understands the risks to her children and does her best to protect them, but this becomes difficult because of her own victimization. If the children's mother is being victimized, her resources for exhibiting positive parenting skills may be compromised.

Young children exhibiting the surrender response may appear calm, but stress hormones are still flooding the brain and disrupting developing brain circuits. Infants and toddlers who tend to this stress response can seem numb and withdrawn and show little emotion.

What is happening in the young child's brain in situations of physical or sexual abuse or exposure to domestic violence is invisible to the naked eye, though increasingly sophisticated brain imaging techniques give us evidence of the effects of trauma on the developing brain. What *can* be seen—though often misinterpreted—are the cognitive, emotional, and behavioral problems that children with PTSD display.

Children with PTSD may have nightmares, show particular distress whenever they are reminded of the traumatic event, or seem "stuck" on re-experiencing the event, incorporating it into their drawings or imaginative play. While some children tend to be hypervigilant and always on edge, others seem numb and withdrawn. They may temporarily regress to an earlier stage of development and lose a skill they once had—like talking in complete sentences (ZERO TO THREE, 2005; Scheeringa & Zeanah, 2001).

The pattern of PTSD symptoms can vary from child to child. Many children who have been chronically traumatized tend to startle easily, become irritable or angry (even when unprovoked), and are hyperalert to any possible signs of threat, even when one is not present. This type of response is called the "hyperarousal response." This type of behavior can be judged harshly by adults, who usually do not realize that the child is traumatized.

Another pattern of response looks very different from hyperarousal. In this second pattern, when a child's cries for help are either not responded to or followed by more abuse, the infant or toddler gives up and becomes quiet and withdrawn. This is called the "defeat" or "surrender" response. Unlike children who show a hyperarousal response, blood pressure and heart rate dip below normal for children in the surrender state. While the young child may appear calm, stress hormones are still flooding the brain and disrupting developing brain circuits. Infants and toddlers who tend to this stress response can seem numb and withdrawn and show little emotion. As they get older, they may avoid people and situations. They may also go along with other people's demands, as if they have little will of their own. While many children who have been traumatized tend to show one or the other pattern, other children can show signs of both hyperarousal and surrender at different times (Perry et al., 1995).

From this description, we can see why chronic violence in families—including physical or sexual abuse, or witnessing domestic violence—can often lead to traumatic stress. Abuse in families tends to be repeated, and different types of abuse often occur in the same household. The fact that this stress response cycle is

repeated in a brain so young means that actual structures of the brain can be affected. Because the structures are affected, children will often show symptoms of traumatic stress in their daily lives, even in situations where there is no longer an actual threat. There is another reason that family violence can be so detrimental for a young child. A young child's most fundamental need is to be able to rely on the caretaker as the provider of predictability and protection. The expectation that the caregiver will help the child safely navigate the world is one of the first casualties of growing up in a violent home. In instances in which the main caretaker is not the abuser, but is the victim of abuse herself, this bond between mother and child is also at risk.

Although researchers and clinicians working with children affected by toxic or traumatic stress have gathered extensive evidence about its impact on young children, this information is still not widely known. Parents and other caregivers often believe that these adverse experiences cannot do lasting harm to children so young. Even professionals—including people working in child care, medicine, and mental health—can underestimate the effect of these experiences on young children. One crucial role of the responsive community is to inform parents, caregivers, and professionals that young children are the ***most*** vulnerable to the damage that is caused by these abusive or otherwise threatening experiences. It is essential to protect the healthy development of children by sheltering them from danger—and by responding promptly and effectively when they have not been protected (Chu & Lieberman, 2010). *Healthy Moms, Happy Babies: A Train the Trainers Curriculum on Domestic Violence, Reproductive Coercion and Children Exposed Kit* is a resource created to support states and their home visitation programs in ensuring that all home visitation programs are equipped to help women and children living in homes with domestic violence (available at http://www.futureswithoutviolence.org/userfiles/file/HealthCare/HV_Trainer's_Guide_Low_Res_FINAL.pdf)

SIGNS OF STRESS IN YOUNG CHILDREN

Infants

Infants depend on adults to look after them. They sense the emotions of their caregiver and respond accordingly. If the adult is calm and responsive and is able to maintain the daily routine, the child will feel secure and symptoms will be minimized. If the adult is anxious and overwhelmed, the infant will feel unprotected and may display a variety of symptoms, including—

- Cries more than usual;
- Sleeps all the time or has trouble sleeping;
- Eats more or doesn't want to eat;
- Becomes less responsive;
- Seems withdrawn or "shut down;" or
- Startles easily.

Toddlers and Preschoolers

At this age, children begin to interact with the broader physical and social environment. As with infants, toddlers depend on adults to look after them and will often respond to traumatic situations as well or as poorly as their adult caretakers. Common reactions in toddlers include any of the signs that you would see in infants (above), plus—

- Has frequent temper tantrums;
- Behaves like a younger child (wetting himself after he has mastered potty training or speaking baby talk);
- Is clingier than usual; or
- Asks many questions about the event, and the answers do not soothe the child.

What Parents and Caregivers Can Do

- Schedule time alone with the child;
- Soothe the child by singing and rocking;
- Keep a regular routine;
- Use storybooks to talk about feelings;
- Shield the child from violent or disturbing TV or books;
- Don't leave the child with people she doesn't know well;
- Explain what will happen ahead of time to give them a sense of control.

Keep in mind that some of the behaviors listed above are common to most children at times (feeding problems, sleep problems, temper tantrums), which sometimes makes it hard for parents to distinguish between typical behavior and reactions to extreme stress. If parents have tried the suggestions above, and the child still shows stress reactions, provide them with names of referrals to well-respected mental health providers in your community. If you need additional help to find therapists who have training in work with trauma in adults or children, see: http://helpguide.org/mental/emotional_psychological_trauma.htm#finding.

Source: Adapted from Safe Start Center (2009).

Toxic Stress from Lack of Responsive Care

Young children do not have to experience or witness violence to have a toxic stress response. Studies consistently show that infants and toddlers who are physically and emotionally neglected also show signs of toxic stress (Bugental, Martorell, & Barraza, 2003; Loman & Gunnar, 2010), as do children of mothers who are severely depressed (Gump et al., 2009) or abuse alcohol or other substances (Carlson, 2006). What these situations have in common is the lack of responsive care on the part of the parent or caregiver. It doesn't matter if the lack of responsive care is because the parent is depressed, abuses drugs, is in a violent relationship, or struggles with extreme poverty—any of these situations can leave a child dealing on his own with challenging experiences before he is mature enough to handle them. In all of these situations, parents have a difficult time addressing their child's need for nurturing, guidance, and appropriate limit-setting. Day after day, these experiences can cause harmful stress responses in the child, including extremes of stress hormones that cause long-term damage.

Children found under the law (or by the legal system) to have been neglected vividly illustrate this. By definition, neglected children are growing up without a responsive adult in their lives. Studies have found that cortisol levels in neglected children can be as unstable as they are in children who are physically abused.[2] Other studies have found that, compared to physically abused children, neglected children actually have more severe deficits in learning and school achievement, are more likely to be withdrawn around people, and tend to show more anxiety and depression.[3] In fact, deaths of children due to maltreatment are more often caused by neglect than by physical abuse (Child Welfare Information Gateway, 2008). This is not meant to minimize what happens to children who are physically or sexually abused. It is just to point out that neglect can be extremely harmful to a child, even though it is often overlooked. Physically and sexually abused children, on the other hand, tend to show more aggressive behaviors than neglected children, as well as more symptoms of PTSD (Pears, Kim, & Fisher, 2008).

When the child's mother is a victim of domestic violence, parenting can also be compromised. Women who are physically or emotionally abused by their partners often have symptoms of anxiety and depression, and if the abuse is severe or repetitive, they may develop PTSD. Mothers who have PTSD tend to be quicker and more impulsive in their actions toward their children and can also underestimate their children's distress (Chemtob & Carlson, 2004).

Studies looking at the effects of exposure to domestic violence on young children have found that if the mother can retain the ability to parent under the stress of family violence—for example, she is still able to set limits and to discipline without harshness—the child can be protected from the most serious problems in adjustment (Graham-Bermann et al., 2009).

One of the most promising treatments for children exposed to domestic violence focuses on strengthening the relationship between the child and the non-offending parent, usually the child's mother. A number of interventions are designed to improve the parent-child relationship while addressing issues related to the child's trauma. One example is Child Parent Psychotherapy (CPP). CPP is a treatment model specifically designed to use with parents and children who witness domestic violence. It is based on attachment theory but combines and integrates principles from multiple theories (developmental, trauma, social-learning, and psychodynamic and cognitive behavioural theories) to help parents and their children recover from exposure to violence. It focuses on enhancing the mother's capacity to provide safety and developmentally appropriate caregiving to her child. CPP has been shown to reduce PTSD symptoms in both mother and child (Ippen et al., 2011). It is an example of early intervention that can help reduce the risk of future mental health problems in the child. Such treatment models also can help break the intergenerational cycle of violence and abuse which often occurs in families affected by domestic violence.

Monica, like many caregivers who grew up with a mother who was depressed, missed out on the experience of frequently being talked to as a child.

Children growing up in families where the main caregiver is depressed often show the same type of outcomes as children who are neglected, including learning problems and lower achievement in school, as well as symptoms of depression and anxiety. Depressed mothers are often preoccupied with past experiences that were negative or overwhelmed by chronic worry about the future. Depression also increases feelings of guilt, including guilt about not being a "good mother." These feelings make it hard for the mother to respond to her child's needs, even the need for physical protection. Studies show that, similar to families where there is legal neglect, children in families where the mother is clinically depressed are more likely to be exposed to dangerous situations than children in other families

MOTHERS AND BABIES

Mothers and Babies/Mamás y Bebés is a curriculum-based program designed to reduce the risk of a major depressive episode in mothers-to-be. This intervention was first designed for Spanish-speaking immigrants because studies show that, although immigrants have comparatively low rates of depression and substance abuse disorders when they first arrive in the United States, the longer they remain here, the more symptoms they have (Daw, 2002).

The course teaches mothers-to-be mood management and self-efficacy skills. There are 12 weekly sessions during pregnancy, followed by four "booster sessions" during the year after birth. You can download the course manuals for both facilitators and participants (English and Spanish versions) on the Web at http://www.medschool.ucsf.edu/latino/Englishmanuals.aspx. Classes using this curriculum have been based at public clinics, Early Head Start centers, and "community hub" elementary schools and churches, among other sites. There is also an informative blog in Spanish for women who have taken the course and want to keep up with new information and gain support while they are young mothers. For more information, see http://mamasybebesblog.blogspot.com/2010/01/ingles-para-preescolares-en-internet.html.

(Mental Health America & Substance Abuse and Mental Health Services Administration, 2009). This makes sense, because mothers who are depressed often feel fatigued, helpless, and ineffective as a parent.

Mothers who are depressed also tend to speak less to their children, and their speech is less animated (Petterson & Albers, 2003). Children who are spoken to more when they are very young are more likely to have larger vocabularies and more developed cognitive skills as they get older (Pan, Rowe, Singer, & Snow, 2005). This simple action—talking and listening to your child—is one of the best ways to make the most of his or her critical brain-building years (ZERO TO THREE, 2011b). Monica, like many caregivers who grew up with a mother who was depressed, missed out on the experience of frequently being talked to as a child. She may need to be reassured that Ella only needs simple verbal responses or simple statements—"see the dog, Ella?"—for the baby's language centers in the brain to be strengthened. However, if Monica is experiencing depression herself, she may need to be encouraged to seek treatment.

All of these symptoms of depression make it difficult to be available to a child. However, medication and therapy have been shown to help reduce symptoms of depression in mothers with young children. Innovative approaches to reduce stress, like regular massage therapy from a partner, have also proven helpful in reducing depressive symptoms in women who are pregnant or have just given birth (Field et al., 2009). Studies show that reducing the mother's symptoms of depression is often not enough to enhance the well-being of the child. The most effective treatments focus on both relieving the mother's depression and strengthening parenting behavior and interactions between mother and child (National Scientific Council on the Developing Child, 2009). When depression does not respond to treatment with medication or therapy, psychologists have also designed programs to teach parents struggling with depression ways to still give their children the attention they need (Mayers & Buckner, 2008; Berkule, 2007). For more ideas on how to respond to this very serious threat to the caregiver and to her children, see the Action Steps on page 28.

Caregiver Substance Abuse Increases the Chances of Toxic Stress

A parent or caregiver's substance abuse can also create situations of toxic stress for his or her young children. Parenting skills are likely to deteriorate when parents abuse alcohol or drugs (Eiden, Colder, Edwards, & Leonard, 2009). Substance-abusing parents tend to spend less time with their children and are more socially isolated from forms of community support than other parents. Addiction to substances can make it difficult for a parent or caregiver to be engaged in a warm, positive way with children (Eiden et al., 2009), with studies

TREATMENT FOR MOTHERS WHO ABUSE SUBSTANCES

Comprehensive substance abuse treatment programs that take into account the particular needs of mothers who are chemically addicted have been shown to have better results than traditional programs. As a group, women who abuse substances have different characteristics than men who abuse, and these need to be taken into account when designing a program. Unlike men, most women with a chemical addiction are primary caregivers, often with several dependent children. Their children are affected by their substance abuse. For most of these mothers, the strongest motivation for ending their addiction revolves around their children—keeping their children, getting them back from out-of-home care, and becoming a better parent.

Substance-abusing women are much more likely than men to report a history of physical or sexual abuse in childhood, or current abuse by a partner as an adult. In fact, in almost every study that asks about trauma and substance abuse, the great majority of women report traumatic experiences. This trauma results in emotional pain, leading the woman to self-medicate with alcohol or illegal or prescription drugs.

Comprehensive treatment programs that take these two factors into account—the role trauma plays in women's addiction and the importance of their maternal role—have higher rates of program completion and lower rates of relapse. Evaluations of many of these programs also show that the quality of the mother–child relationship has improved. Child care and training on parenting skills are crucial components of these more successful programs. If unaddressed, problems in parenting can build and trigger a relapse. Some programs also offer more intensive parent–child therapy to rebuild the trust that can be broken when parents abuse substances.

Intense negative feelings that have been self-medicated can easily arise when substance use has ceased and new coping skills have not yet been developed. At that point, women are at the greatest risk of relapse. For this reason, the most successful programs include mental health clinicians to help women address these intense feelings of past trauma and establish new forms of coping.

SAMHSA's Center for Substance Abuse Treatment (CSAT) provides a search tool to find outpatient and residential treatment centers to fit the needs of mothers and their children. Go to http://findtreatment.samhsa.gov/ and use the detailed search option. Here you can specify treatment options for women, including pregnant and postpartum women, and residential facilities that provide space for children to stay with their mothers while they receive treatment.

Source: Carlson (2006).

showing that they are less likely to be nurturing and emotionally available (Miller-Heyl, MacPhee, & Fritz, 1998). The inconsistent or erratic parenting often found in substance abusing families can leave the child feeling insecure about this crucial relationship between parent and child. Rules and limits are often not clear in families with substance abuse problems, adding to the young child's confusion about what is acceptable and what is not. And because caregivers become irritated or frustrated more easily when they abuse substances, children can be disciplined harshly when they cross what is often an unclear line (Pears, Capaldi, & Owen, 2007).

This inconsistent and harsh parenting can lead to child maltreatment. In fact, studies show that children in families with substance abuse problems are almost three times more likely to be abused and four times more likely to be neglected than other children (Reid, Macchetto, & Foster, 1999). Other studies show that 50 to 80 percent of all cases of abuse or neglect involve parental substance abuse, with alcohol, cocaine, or methamphetamine the most abused substances (Children and Family Research Center, 2002).

Unfortunately, families rarely struggle with only one of these problems. One study (Glaser, 2000) found that 46 to 90 percent of all child welfare cases involve more than one type of maltreatment. Each of these experiences compounds the risk to the child, increasing his risk for toxic stress. The greater number a child experiences, the greater the likelihood of developmental delays and other problems. In fact, in a study of more than 17,000 adults sponsored by the Centers for Disease Control, each adverse situation that happened to adults during their childhood (including neglect, physical or sexual abuse, or having a parent who abused alcohol or drugs, was depressed, or was in a violent partner relationship) added to their risk of having serious health and psychological problems in adulthood (Anda, Felitti, Walker, & Whitfield, 2006).

Once again, the lesson is to prevent these situations before they happen or to intervene with the family as soon as possible. In addition to providing the best help to children and families, prevention and early intervention are also the most effective use of community time and resources. For children and families who have already experienced toxic stress due to trauma or caregiver mental health or substance abuse problems, professional treatment is needed. The National Child Traumatic Stress Network (http://www.nctsnet.org/nccts/nav.do?pid=hom_main) is one resource for referrals to mental health professionals who are trained in the treatment of families affected by trauma and other experiences that result in toxic stress.

ACTION STEPS:

- **Provide training on reading the signs of stress in infants and toddlers to community groups and professionals who have contact with children. For downloadable slide cards on these signs, go to http://www.safestartcenter.org. At the same site, you will find a guidebook for families, Healing the Invisible Wounds: Children's Exposure to Violence http://www.safestartcenter.org/pdf/caregiver.pdf, that gives parents and other caregivers useful ideas on how to help children exposed to family or community violence. Bring copies of this resource to the trainings for community members to distribute.**

- **Direct professionals, including those working in early child care, health care, and law enforcement, to national centers dedicated to helping children exposed to violence. The Safe Start Initiative is funded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. It has put together a wealth of resources for professionals, including a guide to proven and promising programs, a science digest highlighting the latest research in the field, curricula, training**

materials, video presentations for professionals, and a toolkit used to design programs for children exposed to violence http://www.safestartcenter.org/resources. The National Child Traumatic Stress Network offers additional resources for clinicians and other professionals working with families and communities where violence or disaster has occurred, including online training opportunities http://learn.nctsn.org/course/category.php?id=3. Other resources on its Web site include a video to train police for when they are responding to a situation of domestic violence that includes children http://www.nctsn.org/nctsn_assets/acp/dv/NCTSN_DV_rev1.htm#.

Poverty Increases the Chances of Toxic Stress in Families

Families coping with trauma or mental health or substance abuse problems can be found in every economic class, race, or culture. But families living in poverty typically confront more stress-creating circumstances than other families, including chronic poor health conditions, higher rates of unemployment, and substandard housing and schools. In addition to individual families having fewer economic resources to help cope with these adverse circumstances, low-income neighborhoods often lack the supportive institutions and social networks that are found in other neighborhoods. Because of these conditions, when children living in poverty are subjected to toxic stress situations they tend to have worse outcomes than other children. Many leaders focusing on improving the welfare of children in the United States make a good case for targeting the limited resources available for this purpose on financially disadvantaged families, arguing that resources used in this way would have the biggest impact (and the biggest financial payoff for society).

Poverty can also affect children's levels of stress in other ways. Studies have found that neighborhoods that are crowded or chaotic have been found to lead to chronic stress responses in children and adults, including elevated cortisol levels (Evans & Stecker, 2004). This type of "environmental stress" has also been found to leave caregivers feeling chronically overwhelmed and powerless to control their daily life.

Street violence is also more common in impoverished urban neighborhoods than in other communities. While exposure to violent incidents in the neighborhood or school increases with age and is more common among teenagers, children can also witness vivid scenes of community violence. Exposure in young children can lead to depression and PTSD. In fact, young children are likely to display more symptoms of depression than adolescents, perhaps because they cannot express their thoughts and feelings about what they have seen and are less able than adolescents to actively seek comfort from others. Parents may also believe that neighborhood violence does not affect their young children (Fowler, 2009).

Many Caregivers Are Grappling with the Effects of Toxic Stress Themselves

To be responsive to families struggling with mental health problems, substance abuse, or trauma, we need to keep in mind that many caregivers experienced toxic stress when they were children. Like Monica, and Monica's parents before her, they have been subjected to trauma or other situations that cause toxic stress (Knitzer & Lefkowitz, 2006; "Low Income Mothers Have High Rate of Postpartum Depression," 2010; Regier, 1990). The brain research on the effects of such stress can help us have a more compassionate approach to parents and other caregivers. What may seem like a willful refusal of help may be a brain on high alert, sensing a threat. Parents and caregivers may not have had very positive experiences of "helpers" in the

past and initially may be fearful or unable to trust those offering help. People from historically oppressed groups may be particularly wary, given the abuses that minority groups have encountered in the past at the hands of people in authority. And just as common as feelings of distrust are the feelings of hopelessness and helplessness that often go hand-in-hand with frequent experiences of adversity.

While it's important to be able to acknowledge to the parent or caregiver that you know they are facing difficult and often painful experiences, you also need to let them know that you see their strengths and capabilities. They have likely survived many challenging situations. More than any specific strategy to engage families struggling with these problems, successful programs demonstrate a genuine desire to understand each family's unique history and circumstances, and a respect for the road they have travelled.

ACTION STEPS:

- Learn more about the devastating impact that caregiver depression can have on a family by downloading Maternal Depression: Making a Difference through Community Action (http://www.nmha.org/go/maternal-depression).

- Inform OB/GYNs, pediatricians, and other health care workers in the community about the importance of screening for depression, anxiety, domestic violence, PTSD, and substance abuse in pregnant women and new mothers. Though valid screening tools are readily available (see Appendix C), one study of primary care physicians found that only 20 percent used any formal screening tool to assess depression among women who had recently given birth (Sleath, Thomas, Jackson, West, & Gaynes, 2007). You may want to enlist the help of a health care worker to strategize about the best way to approach others in the field.

- Launch an awareness campaign about the importance of mental health and substance abuse problems and direct mothers-to-be to screening sites, doctors, or other health care workers who you know will provide screenings. Target sites where caregivers go, including day care centers, churches, and grocery stores. Low-income mothers have been found to have especially high rates of postpartum depression—48 percent showed signs of clinical depression in a recent study (Roggman et al., 2002). For this reason, screenings at Women, Infants, and Children (WIC) Centers and Temporary Assistance for Needy Families (TANF) offices may be particularly beneficial.

- Connect returning military personnel to "virtual counseling," for depression and PTSD through the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Web site at http://www.dcoe.health.mil.

- Contact the local Mental Health of America (http://www.nmha.org) office in your State to find out how to conduct brief self-report screenings for depression at health fairs.

- For a more in-depth review of issues surrounding parental depression, see the Institute of Medicine report, Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention (http://www.nap.edu/catalog.php?record_id=12565).

Creating Responsive Systems to Reduce Caregiver Stress

Unfortunately, the way our services for families have developed often adds stress to a family already overstressed. Having parents set up appointments at different agencies in different parts of town for each child in the family almost guarantees that many children will "fall through the cracks." One way a responsive community can tackle this issue is to make services and supports as comprehensive as possible. Mary's Center in Washington, DC, is an example of an agency that developed over time to include many essential services under one roof.

MARY'S CENTER

Mary's Center began as a small agency in 1988 in Washington, DC, to provide prenatal care for immigrant women from Central America. Today, Mary's Center is a Federally Qualified Health Center that provides multiple services to underserved families from the United States, Latin America, the Caribbean, Africa, the Middle East, and Asia. It has a truly comprehensive approach to serving families. The center provides physical and mental health services for all ages, a home visiting program for families of children from birth to 5, support for families with children with special needs, after school and case management programming for adolescents, parent support through education and case management, and family literacy classes. It provides training and technical assistance to adults who are interested in becoming licensed childcare providers or opening home-based day care centers. Mary's Center also informs families about educational, housing, and employment resources available to them. (Mary's Center staff speaks more than 27 different languages.) For more information, see http://www.maryscenter.org/services.html.

Another model is to add services that support the "whole child" or "whole family" to an institution that already has connections with parents. In many cities, the concept of a community school has taken hold—with elementary and middle schools becoming vibrant community hubs. These school–community collaborations use existing school space for a range of classes, activities, and events that are open to everyone in the community. Some offer early childcare programs for infants and toddlers, health clinics for children and adults, parenting skills classes, art programs for all ages, and on site mental health care. Parents become leaders at these hubs, and many communities are revitalized in the process. There are now 3,000 to 4,000 of these community hubs in the United States, most falling under one of two models: the Coalition for Community Schools http://www.communityschools.org or School of the 21st Century http://www.yale.edu/21C.

In Santa Fe county, NM, a recent grant through SAMHSA's Project LAUNCH initiative is being used by community residents of public housing projects to plan additional community services on site. Although these models do not provide everything at one site, they go a long way toward helping communities think in terms of being responsible for all of their members. For a detailed look at how New Mexico assessed its need and capacity for this program, and how it engaged different stakeholders in the process, see http://www.earlychildhoodnm.com/attachments/273_ProjectLAUNCH.NewMexicoState.EnvironmentalScan.29may09.pdf. For more information on this and the other 17 Project LAUNCH sites, see http://www.earlychildhoodnm.com/attachments/273_ProjLaunchBriefSheet.pdf.

ACTION STEPS:

- Assess the agencies in your community that serve children and families to see how they might be combined so that families won't have to travel to separate locations, fill out multiple forms, and interact with several professionals at once.

- Look at the possibility of placing any new services (health clinic, early childcare center) at sites where parents of young children go—an elementary school, community center, or faith institution.

Prevent Toxic Stress Before It Happens by Protecting Children

Unlike a generation ago when Monica was growing up, the science is now clear that very young children are affected by what they see, hear, and feel. This knowledge can help us head off situations that are likely to trigger stress responses in young children. In some situations, a little creative planning can prevent possible trauma. For example, in North Dakota, prisons use video chatting so that incarcerated family members can communicate with partners and children. Not only does this save the stress of traveling long distances for families, it also prevents children from having to see the living conditions at the prisons and the disturbing image of their incarcerated parent. More effort is also being made to help military personnel stay in touch with their families by use of video technology, potentially reducing the stress responses that long separations can cause.

The Ounce of Prevention Fund (OPF) oversees the development of high-quality early childcare centers in several urban neighborhoods in the United States. In planning these centers, OPF takes care to design the physical space so that children have an outdoor place to play but are shielded from witnessing the street violence that might occur. While your community may not be able to afford building such a center from the ground up, the idea of protecting the psychological safety of the children, as well as their physical safety, is one that every community can incorporate into its planning.

In Section 3, we will look more closely at the five protective factors that have been found to build resilience in children, their families, and their communities and highlight examples of proven or promising approaches.

SECTION 3:

BUILDING A STURDY FOUNDATION FOR CHILDREN: PROTECTIVE FACTORS THAT PROMOTE RESILIENCE

All families have stress, but not all stress harms children. In this section, we will look at five protective factors that can help all families in our communities but are crucial for families struggling with mental health problems, substance abuse, and trauma. Many of these protective factors help families manage their lives so that they can keep stress at a tolerable level. Others directly contribute to the child's emotional and cognitive development. They all promote the resiliency that every family needs to confront life's inevitable difficulties.

There are hundreds of programs and approaches your community could embrace, but those highlighted here have proven track records. Choose a protective factor that you can address in your community. Remember that one or two improvements in family functioning can affect the entire family system. What may at first glance seem like a small step (like screening a mother for depression and giving her a referral) can eventually lead to big outcomes for the family. Even small steps can give families hope.

As you read through this list, create your own checklist—

1. Things you can do by yourself
2. Things you can do with the help of the child's caregivers
3. Things you need to encourage caregivers to do on their own

Then, on a broader level—

- Things you can do with a small group of community members
- Wide-scale efforts that take collaboration with community partners

In Section 4, we will provide a framework that helps you to look at these choices more systematically.

USING EVIDENCE-BASED PROGRAMS AND PRACTICES

SAMHSA has developed the National Registry of Evidence-Based Programs and Practices, a searchable database of interventions for the prevention and treatment of mental illness and substance abuse disorders. SAMHSA has developed this resource to help organizations choose and implement programs and practices in their communities that have been evaluated and found to have successful outcomes. This Web site allows you to search a database of treatment and prevention programs by area of interest (mental health, substance abuse, trauma), geographical location, use with different ethnic groups, use in different settings (inpatient, outpatient, community), and other factors. See http://www.nrepp.samhsa.gov/.

Five Protective Factors: Building Opportunities for Responsive Caregiving in Families and Communities

We have seen how crucial it is for young children to have at least one adult they can depend on to respond to their basic needs—including their emotional needs. Studies have shown that the following conditions help determine whether caregivers can parent effectively, even in stressful situations:

- Concrete resources in times of need;
- A support system for the family;
- Emotional and psychological resilience of the caregiver;
- Parenting tips, information, and skills courses for caregiver; and
- The child's social-emotional and cognitive capacities.

By building these five protective factors with families, a responsive community can increase the chances that the child will have at least one adult to provide the child with consistent, nurturing care:

#1 Help the family with concrete resources in times of need.

Families in need of food, housing, transportation, and employment are particularly stressed. Help families in stressful circumstances locate housing, find child care for their children, and fill out forms for entitlement programs that may be confusing or not in the caregiver's native language. These acts may take a few hours of your time but can change a family's future. Develop a mentoring program for the unemployed by using active or retired business people in the community to provide information and support. Boca Helping Hands in Boca Raton, FL, is one successful example of this strategy: http://www.bocahelpinghands.org.

Respite care for children is a concrete support that can be a powerful intervention to help a family prevent child abuse. Two examples of model programs (Melton & Anderson, 2008) for respite care to help prevent child abuse in overstressed families include Safe Families (http://safe-families.org) and Strong Communities (http://www.dukeendowment.org/issues/children/child-abuse-overview/strategy). These programs match a volunteer family with a family in need. The host families care for children for days, weeks, or months, with the consent and appreciation of the family in need. Meanwhile, caregivers are connected to support and resources. The goal of these groups is to return the children to the care of their families after the caregivers have been supported with treatment, training, concrete supports, or whatever else might be needed.

#2 Help the caregiver strengthen his or her support system.

Families dealing with mental health problems, substance abuse, and trauma are often isolated, and this isolation can lead to further distress. Schools as community hubs (see Section 2) are a natural way to bring parents together and encourage connections among all families—those who are experiencing significant stress and those who have not had as much distress or have found ways to cope with it. Obviously, this solution takes long-range planning and large amounts of time and energy from a committed community, but it can reap big rewards for isolated families and their children.

The Kitchen Table Project is a group started by women from low-income neighborhoods in Cambridge, MA, to counteract the feelings of powerlessness and isolation that often go along with living in poverty (Goodman et

al., 2007). ROAD (Reaching Out about Depression) grew out of the Kitchen Table Project when it became clear that a majority of the women in the group struggled with symptoms of depression. The women of ROAD believe that the lack of resources, higher rates of stressful events, and more frequent threats to health that occur in low-income neighborhoods can contribute to their symptoms. They have taken this message to traditional mental health care services and use a community activist approach to improve what they believe to be a flawed system when it comes to understanding issues of poverty, powerlessness, and depression. The women work together to develop workshops on well-being, consulting with professionals when needed. ROAD also puts together a list of supports and resources to be used by the group, including those that encourage alternative methods of treatment. They then bring their ideas and suggestions to the doctors and therapists in their community so they can develop better services. This model has developed strong bonds among ROAD members. For more information, see http://www.reachingoutaboutdepression.org.

Some groups have found particularly creative ways to engage caregivers in group activities. Book and writing groups can be an engaging way to promote self-awareness and foster lasting bonds. In low-income neighborhoods in Chicago, Literature for All of Us creates book groups for young, single parents, many of whom have experienced significant trauma in their lives. The adult mentors for these groups provide a safe space for teen mothers to explore what has happened to them, to reaffirm their strengths, and to create a vision for the kind of experiences they would like their own children to have. Evaluations (Maschinot, 2010) show that this model supports positive coping, and fosters friendship among the participants. The books chosen need not be about parenting. In fact, the book group can honor the fact that the caregiver is not only a mother but also a woman in her own right by choosing novels with characters and situations that resonate with the participants. Ask a bookstore (or another business in the community) to be your sponsor and donate the books to the group if money is tight. For ideas on how to start your own book group and suggested books, see the Web site for Literature for All of Us at http://www.literatureforallofus.org.

Community gardens are another way to bring families together. There is a vibrant community garden movement, with gardens in urban neighborhoods from New York City to Los Angeles, and in thousands of smaller cities and towns in between. To view some examples, see http://www.cityfarmer.org/communitygarden7.html. For information on how to start a community garden, including a video and tips for finding funding, see the American Community Garden Movement's Web site at http://www.communitygarden.org/learn/starting-a-community-garden.php. Make sure to advertise that small children are welcome, provide healthy snacks, and appoint responsible and trusted volunteers to play with the children who are too young for gardening.

These ideas—book groups and community gardens—are presented as ways to jump start your thinking. They are just two examples of what you can do. While they have been used successfully to bring families together in places as diverse as lower-income urban communities to small, rural towns, you may need to conduct an informal survey to determine what might be welcomed by the families in your community. Make sure you have input from people who reflect the cultural diversity of the population you are trying to reach. Another option would be to find a few people who have a passion for an activity that would likely attract families and find ways to support them. These types of creative ideas work best when the people developing them have a real interest of their own.

A responsive community can also encourage caregiver connections at natural meeting points: day care or Early Head Start centers, YMCAs, churches, synagogues, and mosques. Organize activities that are fun and help caregivers de-stress. If you are not sure what activities caregivers might like, find ways to ask them (a brief survey at a clinic or preschool, for example). It is not the number of friends or other connections that a caregiver has, but rather the quality of the relationships that matter (Beeman, 2001). Those relationships that are generally positive, trusting, reciprocal, and flexible go a long way toward helping develop resilience in families.

#3 Find ways to directly address the emotional and psychological resilience of the caregiver.

Caregivers wounded by their own past or present trauma—perhaps turning to drugs or alcohol or showing signs of depression or anxiety—can be too preoccupied to correctly read a child's signals. For parents or other caregivers struggling with problem drinking, motivational interviewing (MI) is one counseling technique that has been used successfully in a variety of situations to reduce problem drinking. MI is based on the assumption that many problem drinkers have both positive and negative feelings about their drinking habits. Helping the client explore this ambivalence, and resolve it, is the key goal. MI has been applied to a wide range of problem behaviors related to alcohol and substance abuse as well as health promotion, medical treatment adherence, and mental health issues. For more information on MI, see http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=130.

TRAUMA AFFECT REGULATION: GUIDE FOR EDUCATION AND THERAPY (TARGET)

TARGET is a strengths-based approach that has been found to help parents or caregivers regain control of their daily functioning after they have been subjected to physical, sexual, or emotional trauma. Using simple language, TARGET describes the stress response system in much the same way as it is described in this guide: as an alarm in the brain that is triggered by trauma or other stressful circumstances. When the brain becomes stuck in alarm mode, a person cannot access the brain's capacities for clear thinking and therefore reacts to all types of current stressors as survival threats. This can cause serious difficulties in relationships and daily life activities. To address these difficulties, the TARGET program teaches parents a set of seven skills (summarized by the acronym FREEDOM—Focus, Recognize triggers, Emotion self-check, Evaluate thoughts, Define goals, Options, and Make a contribution), each of which helps "turn down" the brain's alarm system. Several evaluations of the program show that, compared to traumatized participants who were given standard care, participants who completed the TARGET program showed fewer symptoms of anxiety, depression, and PTSD and were better able to control their emotions in daily life. Also, TARGET participants who abused substances in the past reported that they felt better able to resist the triggers that often lead to relapse. TARGET has been used with men and women from a wide variety of age and ethnic groups in mental health and addiction agencies, domestic violence shelters, child guidance clinics, children's psychiatric hospitals, women's prisons, and group homes. This program can be offered in 10 to 12 individual, group counseling, or psycho-educational sessions conducted by clinicians, case managers, rehabilitation specialists, or teachers. For more information about the TARGET program, see http://www.advancedtrauma.com/html/the_target_model.html.

#4 Provide parenting tips, information, and skills courses for caregiver.

Caregivers from families with histories of violence, neglect, or depression may have had few role models for responding appropriately to their own child's needs. It's important for caregivers to know what children are capable of at different ages. Studies (Valentino, Cicchetti, Toth, & Rogosh, 2006) have shown that caregivers who don't have realistic expectations of their young children are more likely to see their children as "disobedient" or "willful" when they do not measure up to the caregivers' expectations. These negative views of the child can lead to harsh parenting, and even abuse.

ZERO TO THREE provides free informational resources in Spanish and English for caregivers. These include handouts (the *Your Baby's Development* series) that will help parents understand what to expect from infants and toddlers. (See http://www.zerotothree.org/site/PageServer?pagename=ter_par_agebasedhandouts.) Bring copies of these handouts to the many sites where parents and other caregivers are likely to be and obtain permission to place them. Although written to be useful to caregivers, this information is helpful for all members of a community working to be responsive to children and their families. The Child Information Gateway Web site also has useful tip sheets you can download and distribute to parents and other caregivers to help guide them on specific issues, including bonding with your baby, dealing with toddler's temper tantrums, becoming a more involved father, and dealing with the unique challenge of grandparents parenting their grandchildren. These tip sheets may be downloaded individually for distribution from the "Parenting Resources" section of the Child Welfare Information Gateway Web at http://www.childwelfare.gov/preventing/promoting/parenting.

Caregivers in families who have experienced trauma may tend to have "short fuses" due to their own trauma experiences. Tending to a baby who won't stop crying can be a trigger for caregivers under stress. When a caregiver is so frustrated or angry that he or she shakes a baby, Shaken Baby Syndrome (SBS) can occur. This form of head trauma can lead to long-lasting brain damage and other serious health consequences. There are an estimated 50,000 cases of SBS each year. Of these 50,000 cases, about 1,200 are reported, and one-fourth of those babies die, making it the leading cause of death due to child abuse. The majority of cases are instigated by a father or the mother's boyfriend (Centers for Disease Control and Prevention, 2010; Shaken Baby Task Force, 2011).

The Shaken Baby Task Force has developed a public service campaign to warn caregivers of the seriousness of this syndrome and to give tips on how to handle the stress of an infant crying. For more information, including access to the print, radio, and TV media campaign, see http://www.safebaby.org/sbs.asp. Also, the Centers for Disease Control and Prevention (2010) has published a guide to help community organizations identify their role in helping prevent SBS. Parents and other caregivers who feel out of control can also be encouraged to call a parenting

hotline. Childhelp® runs a national 24-hour hotline (1–800–4–A–CHILD) for parents who need help or parenting advice. Other hotlines for crisis situations, or warmlines for general parenting support, can be found in Appendix A.

Families struggling with serious issues like substance abuse, family violence, and mental health problems often benefit from more intensive parent training. The Strengthening Families Program (SFP) is a highly acclaimed parenting skills program. More than 15 evaluations (Center for the Study of Social Policy, 2007) have shown that SFP teaches caregivers how to increase desired behaviors in children by using attention and rewards, clear communication, effective discipline, problem solving, and limit setting. Results show a large decrease in behavior problems in preschool children and a reduction in depressive symptoms (for both children and their caregivers). SFP has been customized for African American, Asian/Pacific Islander, Hispanic, American Indian, and rural families. SFP was originally developed for caregivers with substance abuse problems but is widely used with others as well. It has been used in many settings: schools, churches, mental health centers, housing projects, homeless shelters, recreation centers, family centers, and drug courts. The program also provides ongoing technical assistance. For more information, see http://www.strengtheningfamiliesprogram.org/about.html.

TRIPLE P (POSITIVE PARENTING PROGRAM)

Another highly regarded parenting program, the Triple P (Positive Parenting Program) has trained over 20,000 practitioners worldwide (including health care workers, social workers, teachers, telephone counselors, and others) to provide information, advice, and professional support for parents. The program has a flexible, multilevel framework that takes into account the type and intensity level of assistance the family might need or want. The first level of Triple P gives communities access to media messages on positive parenting and informational resources such as tip sheets and videos. Levels 2 and 3 provide parents with specific advice on how to solve common developmental issues, such as toilet training, and minor problem behaviors. At these levels, there is face-to-face or telephone contact with a practitioner or brief seminars. More intensive parent training at Levels 4 and 5 targets broader family issues, such as relationship conflict and parental depression, anger, and stress. At these levels, caregivers receive intensive training in positive parenting skills (about 10 hours over 8 to 10 sessions). Triple P is also designed to be adopted within larger organizations that work with children. For more information on this highly flexible and successful program, see http://www.triplep-america.com.

When the primary caregiver is unable to provide the care that's necessary, the most important thing a direct service worker can do is to help her determine who might be the best caregiver for the child. Often, convening a group of concerned family members and family friends can help professionals identify the needed help in the family's existing network of support. This group could also decide if help from the formal support system will be needed. This approach, known as family group conferencing, has been used successfully in Australia, Europe, and the United States see http://www.americanhumane.org/protecting-children/programs/family-group-decision-making. It is important to note that foster parents who are relatives of the child do not receive the same subsidies and supports that nonrelatives do. A community responsive to the needs of

kin foster families could choose this as an issue to focus on for advocacy efforts. (See Section 4 for more information on how to advocate for legislative change.) In the meantime, a responsive community can target these kin foster families to provide parent training and other supports that nonkin families receive.

#5 Encourage the child's social-emotional and cognitive capacities.

As we've seen in Section 1, children's resiliency is strengthened by experiences that are sensory rich and emotionally attuned. Newborns need warm and responsive interactions with adults. As they age, infants and toddlers need interactive play. They also need a safe environment to explore. These experiences help to shape the brain and actually make it better able to handle stressful experiences.

The wider community can play a major role in helping the child develop emotionally and cognitively by creating engaging environments anywhere that children congregate.

Children from families experiencing significant stress may have less opportunity for this enriching type of play. Parents struggling with substance abuse or mental health problems may be more irritable and less patient with a child's natural curiosity about the surrounding world and end up limiting the child's healthy need to explore. In fact, this type of toddler behavior—exploring and "getting into things"—can be a trigger for parents who maltreat their children. Studies have also found that 1-year-old infants from abusing families tend to have less opportunity for independent play than do other infants (Valentino, Cicchetti, Toth, & Rogosh, 2006). And other studies show that this type of independent play encourages healthy cognitive development (Planinsec, 2002; Woodward & Needham, 2009).

The wider community can play a major role in helping the child develop emotionally and cognitively by creating engaging environments anywhere that children congregate. Community groups can sponsor indoor play spaces for children at public places (clinics, libraries, churches, synagogues, and mosques). To create the kind of play space that engages young children—and also encourages brain development—see the books and Web resources listed in Appendix A.

Playing outdoors is especially important for young children but is not as common as it once was. For a thoughtful article (White & Stoecklin, 1998) on the impact of outdoor play on physical, cognitive, and emotional development, see http://www.whitehutchinson.com/children/articles/outdoor.shtml. The Mental Health Association in Texas sponsors a Web site with information on parenting that includes a helpful article on how to set up an outdoor space for playing and learning about nature: http://www.texaschildreninnature.org. Gather together your ideas and plans and approach businesses, faith groups, and private citizens to donate some land (it does not have to be a large amount) in an area of the community that has few such resources.

To better educate your group or coalition on the importance of play and thoughtful ways to create enriching experiences for children, designate one or two members of your group to attend workshops devoted to this topic. (For one example, see the Institute on Creating Sustainable Environments for Young Children at http://www.whitehutchinson.com/children/sustainableinstitute.shtml.) Have those members go on a community speaking tour to share ideas with the wider community about how to plan stimulating play spaces from scratch or how to improve existing ones. All of the ideas are based on sound early child development principles, and many are not expensive to put into practice.

In addition to these types of sensory-rich experiences, programs in early childhood education have been

developed to encourage the growth of social-emotional skills in young children. Programming in social-emotional learning (SEL) encourages toddlers and preschoolers to recognize their own emotions and needs and begin to communicate them to other people. In this way, young children gradually begin to manage their own emotional responses (Denham & Burton, 2003). SEL also helps young children begin to understand the perspective of others, which is a necessary step in the development of empathy. These are the beginning steps in teaching the child how to handle interpersonal situations more effectively. They also give the child tools to handle situations without either withdrawing or resorting to overly aggressive behavior (Ladd, Buhs, & Seid, 2000).

Developing social-emotional skills is particularly important for children in families of abuse or neglect. Parents at risk for child maltreatment may not have had the opportunity to develop these skills themselves, which is part of the reason they have difficulty managing their own stress in healthy, non-abusive ways. For this reason alone, children at risk for maltreatment can gain a lot from programs that focus on these skills. Better SEL skills may even decrease children's risk for abuse and neglect at the hands of their own parents, although this has not been well-studied. Children in families who have not seen examples of SEL skills from their parents are themselves more likely to use challenging behaviors to try to get what they want. Because of this, they are at greater risk of becoming caught in a cycle of negative conflict that may escalate into physical abuse.

EARLY CHILDHOOD EDUCATION PROGRAMS AND THE FIVE PROTECTIVE FACTORS

High-quality early childhood education (ECE) programs strive to integrate the five protective factors into their daily work with young children. When staff members in these programs see parents as partners in their children's growth, real relationships between parents and staff can develop. ECE programs can also lay the foundation for a culture of connection among parents. These steps cut down on the social isolation and mistrust felt by many parents in struggling families. Gaining the trust of parents over time also makes it more likely that parents will follow up on a mental health referral for themselves or for their child. ECE programs that are comprehensive can also provide a natural setting for parenting education and support. ECE programs are well-suited to provide these services because they often serve a group of parents with common life circumstances, and they can offer classes and support groups on a long-term basis. If the staff is chosen to reflect the cultures represented by the families in the program, or well-trained on cultural competency, these educational and informational messages will be better suited to the families that attend and better integrated into their daily life. ECE programs are also in a particularly good position to assess and respond to the concrete needs of families because they see them on an almost daily basis. When the family needs material help, the ECE program can serve as a conduit to other agencies that can provide for material resources and link parents to additional services when needed.

Source: Adapted from Center for the Study of Social Policy (2007).

Models that Integrate these Protective Factors

For communities that are ready to take on larger and more ambitious initiatives, there are communitywide models that can provide inspiration and guidance. The Strong Communities Project focuses on changing the culture within target neighborhoods to one of mutual engagement and assistance and, in doing so, reduce the risk of child abuse and maltreatment. The members of the Strong Communities Project believe that once residents feel that their neighborhood is a place where families help each other, and where it is expected to both ask for and offer help, they will be more likely to make wise decisions that enhance child safety.

STRONG COMMUNITIES PROJECT

In South Carolina, Strong Communities Project leaders target neighborhood institutions—schools, places of worship, health clinics, and workplaces—as key players in supporting families and helping to reduce incidences of child abuse. Strong Communities focuses on two broad components. The first is to strengthen communities through the engagement of community outreach workers. Outreach workers have gathered and educated groups of community leaders at every strata—from elected officials and clergy to firefighters and civic club members—and trained them to be advocates and actors for child welfare within their communities. The second component is to organize a large and vibrant network of volunteers to provide direct assistance to the families of young children. This includes the Strong Families program that works to ensure the availability of a volunteer "Family Friend" to watch out for every family with a child under 6 in target communities. It also includes the creation of Family Activity Centers that will offer drop-in playgroups, parents' nights out, parent-child activities, primary social services, financial education, and mentoring.

The Strong Communities approach claims several distinguishing factors, including: its focus on building "social capital" as the principal strategy in preventing child maltreatment; its emphasis on primary prevention; its relevance to all young families; and its incorporation of the assets found in primary community institutions, including some that usually are not directly involved in child protection. For more information on this initiative, see http://www.dukeendowment.org/issues/children/child-abuse-overview/strategy.

Source: Melton (2009).

Many communities across the United States have invested in home visiting programs, which ideally provide all five of these protective factors. Home visiting programs match expectant mothers with trained professionals (nurses, social workers, or paraprofessionals) so they can get the information and support they need during pregnancy and those crucial first 3 years. Through weekly or monthly visits with the family, the home visitor becomes an important source of support for the new family. Most programs help parents with concrete resources, including finding safe and stable housing when needed. They also provide child development information and encouragement so that parents can build more positive relationships with their infants and children. Research shows that mothers who had home visits from visitors trained in early child development were more sensitive and supportive in interactions with their children and had more realistic expectations of their children's behavior (Administration for Children and Families, 2006).

One national home visiting program that uses nurses as home visitors, the Nurse-Family Partnership (NFP), has been widely researched. NFP has been shown to cut incidences of child abuse and neglect up to 79 percent compared to similar families in a control group (Olds, Hill, Mihalic, & O'Brien, 1998). And by teaching parents to stimulate their children's early learning, NFP programs have enabled parents to positively influence their children's cognitive development. For example, one study showed that, at age 6, children who participated in an NFP program had higher cognitive and vocabulary tests than children who did not have the opportunity to have this comprehensive support (Olds, Kitzman, et al., 2004). This early boost continues to pay off for children: At age 9, these same NFP children scored higher on achievement tests in reading and math (Olds, Kitzman, et al., 2007). All of these findings translate into help for families and large savings for the community.

At least five national home visiting models have been shown to positively affect outcomes for both the mother and her child. If your community group decides to focus on developing a home visiting program, your first step would be to read about the differences among these program models and discuss which ones might best suit your needs and resources. One place to start is at the *Supporting Evidence Based Home Visiting* Web site at http://www.supportingebhv.org/home-visiting-models, which is sponsored by The Children's Bureau. Successful home visiting programs tend to work, in part, by reducing stress in families (Administration for Children and Families, 2006). In the past few years, model home visiting programs have also focused on addressing the high rates of maternal depression in families that are eligible for home visiting programs (45 percent of mothers in one large-scale study [Ammerman et al., 2009]. Given the impact of depression on children, a program that responds to this issue can have a more positive effect on long-term family functioning—and children's well-being—than one that does not.

At least five national home visiting models have been shown to positively affect outcomes for both the mother and her child.

Join a National Network

Throughout this Guide, we've pointed out how essential it is for all families to have resources and support from the people and institutions around them. In some situations, well-timed support can help protect families from extreme stress. In others, it can allow them to be more responsive to their child, even though they are dealing with stressful times.

To remain responsive to families, your work needs to be supported as well. Many groups around the country have joined national networks to support the community work they do. While many national

networks offer information and opportunities to connect to other community groups across the country, some national networks also offer in-depth training, technical support, and ongoing feedback.

For example, one such network, The Brazelton Touchpoints Center, partners with local coalitions of providers at sites across the United States who work together to integrate the Touchpoints Approach in their work with children and families. The Touchpoints Approach offers early education professionals a framework to build better partnerships with families around a strengths-based model. This helps to increase parent engagement, which ultimately benefits child outcomes. Implementation of the model varies depending on the site, but usually early childhood educators and health care and social service providers participate in an intensive training program, and receive ongoing technical support and feedback. For more information, go to http://www.touchpoints.org.

Many of the organizations listed in Appendix A are national networks that your organization can join. You will need to research these organizations to determine whether they offer the type of support that will be helpful to your group.

You Can Do a Lot To Help Promote Resiliency in Families

The part you play—as one person, as part of a small community group focusing on one or two issues, or as part of a large, integrated network building wide-ranging protective factors into communities—can have a tremendous impact on families struggling with mental health problems, substance abuse, and trauma. We now know much more about what children need, what families need, and what we all need to do to build stronger and healthier communities. In Section 4, we will lay out a strategic framework that will help you guide your planning process.

SECTION 4:

A STRATEGIC FRAMEWORK FOR ACTION

Unless otherwise noted, this section has been adapted from Maternal Depression Making a Difference Through Community Action: A Planning Guide *(Mental Health America & Substance Abuse and Mental Health Services Administration, 2009), which was developed by Mental Health America in partnership with the National Center for Children in Poverty for SAMHSA and the U.S. Department of Health and Human Services.*

This section offers a strategic planning framework to help communities address these issues impacting families. This section is based on SAMHSA's Strategic Prevention Framework, which is a five-step process being used in communities across the country to develop effective programs and initiatives.

The five steps in the Strategic Prevention Framework are the following:

A. **Assessment:** What does the problem look like and what is driving it?
B. **Capacity:** What do you have to work with and who can help?
C. **Planning:** What are you going to do about it?
D. **Implementation:** Do it!
E. **Evaluation:** Did it work?

The next five subsections will walk you through each step of the strategic planning framework. You will find descriptions as well as tips on how to move forward based on your needs and resources. We recognize that all communities have different needs and resources, and that what works for one community may not work for another. As a result, the strategic planning framework is designed to be a flexible approach that each community can use and adapt to its own circumstances. For more detailed information on this framework, including worksheets and tools to help your group stay on target for each step, see http://www.samhsa.gov/prevention/spf.aspx

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CULTURAL COMPETENCY AND SUSTAINABILITY

Regardless of the circumstances in your community, it is essential that two central concepts are embedded in every step of the process: cultural competence and sustainability. Becoming culturally competent means more than knowing about the visible signs of culture, like traditions, foods, and language. It also means gaining a deeper understanding of the values, beliefs, and assumptions that guide all of us as we face the daily challenges of life.

We all have "cultural scripts" (D'Andrade , 1992; Maschinot, 2008) that we follow, even though they tend to be out of our awareness. These scripts do not dictate behavior in any rigid way, but they do act as a guide. Important topics—like how to raise a child, how appropriate it is to ask for help from someone outside of your own cultural background, how comfortable you are with informal versus formal

support—are often shaped by the worldview of your own cultural group, as well as by your own personal experiences.

An initiative or program has a much greater chance of success when it takes into account the worldview of the people you are trying to reach. You are better able to do this if you are aware of how your own culture and experiences shape your ideas and beliefs. For more on the importance of understanding culture in this way, see http://main.zerotothree.org/site/DocServer/Culture_book.pdf?docID=6921.

Cultural competency must be infused into every step of the planning process. Programs and approaches that work for some populations may seem irrelevant or even threatening to others. Keep this in mind as you develop your program to help ensure that you come up with strategies and activities that resonate with your populations of focus. This will enable you to design programs that feel relevant, meaningful, and safe to the people you are trying to reach.

In order to discover the real issues in the community, the assessment needs to be done in the context of the beliefs and norms of the people you serve. Developing capacity is likely to look very different in an American Indian community than in an urban neighborhood. Planning, implementation, and evaluation activities should also change to fit the people and the circumstances in the community. In order to do this, planners must listen for important distinctions among individuals or groups, value the differences that might be present, and act on them.

Sustainability must also be embedded in the thinking and execution of each step in the process. Make decisions that increase the likelihood of sustaining the outcomes of the plan. Such thinking encourages the development of inexpensive solutions, mutually beneficial financial arrangements, collaborative decisionmaking, and partnerships that ensure that the program, policies, and practices continue to operate over time.

A. Assessment: Determining Your Community's Needs

Determining your community needs is an important part of planning a successful program. It starts with assessing the problem and then identifying your populations of concern.

The more you understand the magnitude and impact of trauma, mental health problems, and substance abuse in your community, the better you can design a program that will address them successfully. These are some of the questions that may help guide your assessment:

1. What is the incidence or prevalence of the problem in your community? (Incidence is the rate of new occurrences of a studied condition in a set period of time, such as the number of people who hurt their back in a month. Prevalence is the total number of instances of a studied condition in a set period of time, such as the number of people who have back problems over a month).

2. Who is affected by the problem, including age, sex, race/ethnicity, economic situation, educational level, place of work, and residence?

3. What is the impact of these issues in your community? What are the effects on individuals, families, and the larger community?

4. What are the factors that put people at risk? What are the factors that help protect people?

5. What are the barriers to accessing supports or protective factors? What are the barriers to accessing treatment?

For a complete list of questions to consider, see Appendix C.

Identify and Learn About Your Populations of Focus

Review the information you collected to identify who in your community is experiencing or is impacted by these problems. Select from this your population or populations of focus. By asking the above questions, you will be able to determine which populations in your community are in need of programs and what their specific needs are.

Once you've selected your populations of focus, you need to learn more about the factors that might motivate them to seek resources, supports, and treatment. You also need to learn more about the factors that might prevent them from doing so. Collect data on what your populations of focus think about trauma and about mental health and substance abuse problems, as well as what they think about seeking help for these problems. This information will enable you to create programs and messages that resonate among the people you are trying to reach.

Once again, when trying to collect this information, make sure you include questions that will help you understand the underlying cultural scripts—the shared values, ideas, and beliefs—of your populations of focus. Think about the following:

- What do the members of the group you have identified think about the vulnerability or resiliency of young children? More specifically, what impact do they think these issues have on young children?

- What do the members of your identified group think about health promotion issues? What do they consider to be appropriate ways to communicate and provide helping services? What needs to be in place for them to be comfortable enough to participate in your initiative or program?

- What are the strengths and the level of resiliency of the members of your intended group? Are they willing to accept help and programs that ask for changes in their behavior, attitudes, and knowledge? What seems to be their capacity to make these changes?

Please refer to Appendix C for additional questions to consider.

Tips on Collecting Data

Collecting data can sometimes be time-consuming and costly. Whenever possible, use existing data that may have been gathered for other purposes but are relevant to your issue. The list below provides helpful sources of local and national data that may already be available to you.

National data—

- Sources of national health statistics from SAMHSA, the National Institute of Mental Health, the National Center for Health Statistics on the Centers for Disease Control and Prevention Web site, and Postpartum Support International (see Appendix A for more information)
- National clearinghouses
- Health-related resources on the Web

Local data—

- Sources of local health statistics from a community hospital or a local or State health department
- Community service agencies (for related service-use data)
- Nurse practitioners and physicians, including internists, family practitioners, obstetricians/gynecologists, and pediatricians (for service-use data)
- Local and State government agencies, universities, and voluntary and health professional organizations
- Administrative databases covering relevant populations (like intake forms from a local women's shelter, or records from early childcare centers)

Schedule a time to meet with some of these sources in person, such as doctors and hospital administrators, and bring the questions in Appendix C to help guide your research. For more information on where to look for data, refer to Appendix A.

Gather New Information as Needed

You may find that the sources of data listed above do not give you enough insight into the problem. Gathering new data directly from mothers, fathers, and other caregivers can help you get answers to your specific questions. One way to gather new data is through focus groups and in-depth interviews. In addition to providing a fuller picture of a community or problem, focus groups can help you interpret the data described in the last section. Well-planned and structured focus groups can also help you develop your action strategy by:

- Gathering new information about the depth and scope of the problem;
- Getting rich, real-time information;
- Gaining insight into the participants' past experiences with interventions, what has been helpful, and what hasn't;
- Learning how best to engage caregivers who may feel stigmatized;
- Identifying cultural differences and cultural scripts that may affect one's approach to the issue; and
- Obtaining input into the design of the community's action plan.

You might consider conducting focus groups and in-depth interviews with parents and other nonparental caregivers, primary care providers, and job-based employee assistance programs. School personnel (for example, teachers, administrators, guidance counselors) and Head Start and Early Head Start programs may also be rich sources of information about these issues in the community. The broader the range of focus groups, the greater the breadth of information obtained. For more information about conducting focus groups, see Appendix D.

COLLECTING NEW DATA ON A LIMITED BUDGET

- **Do the legwork yourself. Convene focus groups and train your staff to moderate them.**
- **Use the help of volunteers and interns.**
- **Recruit participants through partner organizations, friends, family, and other contacts.**
- **Seek professionals with qualitative research experience who might donate their time.**
- **Recruit low-cost experts (for example, a graduate student who needs a dissertation topic) from local colleges or universities.**

B. Capacity: Improving Your Community's Capabilities

Before you can effectively plan an action strategy, it is important to examine your community's capacity to bring about the changes that you would like to see. Capacity refers to the various types and levels of resources that an organization or community has to address these issues. Capacity may include human, fiscal, and capital (for example, buildings or office space) resources. This encompasses the expertise and time of staff or volunteers, facilities, transportation, office supplies, equipment, and other fixed capital needed to ensure sufficient capacity to implement and evaluate sound programs.

If you are working with a coalition, look at each organization's or agency's internal capabilities to see all of the resources available. Whether working with a coalition or by yourself, you may need to seek additional resources to augment those you already have.

Benefits to Assessing Capacity

Assessing your capacity will:

- Help you make a realistic match between the needs you have identified and the capacity of your community to address them;
- Provide the documentation you need to assure yourself and others that you have the ability to reach your desired outcomes;
- Reveal strengths and shortfalls in your capacity in key resource categories;
- Provide an opportunity to make up for anticipated shortfalls, find a way around them, or select another program that better matches your capacity; and
- Help you maximize and leverage existing resources and expertise.

How to Assess Capacity

1. Identify your program needs (staffing, facilities, training needs, time to complete the program, and costs).
2. Determine your community's capacity, including:
    a. Budget available to fund the program or initiative;
    b. Staff and other human resources (for example, board members, existing volunteers, and others who have the requisite skills and time); and
    c. Available resources and information about the problem, including available educational materials.
3. Compare your capacity to your needs.

4. Identify additional resources that can help you meet your needs, such as partnerships with community leaders, the media, volunteers, civic associations, religious groups, neighborhood health centers, women's centers, and so forth.

Building Partnerships

Partnerships are the backbone of nearly every successful community program. Partnerships include a variety of arrangements and levels of engagement to produce results that one organization, community group, or coalition alone could not achieve.

PARTNERSHIPS AT SIX LEVELS OF ENGAGEMENT	
Networking or Communication Links	minimal involvement among groups (mainly to share information)
Publicity Partners	serve as channels or go-betweens to help spread information
Endorsement Partners	publicly endorse each other's programs to broaden appeal or lend credibility
Coordination Partners	remain self-directed but conduct mutually beneficial activities and work together with a common purpose
Cosponsorship Partners	share their resources
Collaboration Partners	work together from beginning to end to create a vision and to carry out a program (coalition building)

Source: Adapted from U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Division of Nutrition and Physical Activity (1999).

Building a Coalition

A coalition is one type of partnership you may pursue. Coalitions allow single organizations and individuals to maximize their time, resources, reach, and impact on the community. Coalitions also help create a shared vision with agreed-upon goals, which increase community buy-in and create a solid foundation for implementing an action plan. The more a strategy represents the whole community and shares a common goal, the more powerful and respected it will be.

Each member of a coalition brings unique resources and expertise to the table that can be used to address common issues and accomplish each of the strategic planning framework steps. You don't have to do it alone. And remember: All of these issues are community issues and thus require communitywide collaboration and action. If a coalition focused on one of these issues doesn't already exist, consider forming one yourself.

Before forming a coalition, think about the following questions:

- What is the vision or mission of the coalition?
- What will the coalition accomplish?
- How, when, and where can you call people together?
- How long will you be together?
- How often will you meet?
- How will decisions be made?
- Who will be the leaders and spokespeople?
- How will you support the coalition?

After you answer these questions, start thinking about which groups or individuals in your community might be a good fit for your coalition and what each could contribute. Make sure to engage a broad group of key stakeholders, such as members of your populations of focus; the local health department; organizations that specifically address mental health, substance abuse, and trauma; organizations that address child and family health issues; community and faith-based organizations; local researchers; school administrators and staff; physicians; and employers.

If joining or forming a coalition is not feasible, you can still move forward on your own. However, as you go through the strategic planning framework steps, occasionally revisit the possibility of taking part in or forming a new coalition. For more information on coalition building, see Appendix E.

TIPS FOR BUILDING AND MAINTAINING A COALITION

- Engage a broad group of key stakeholders.
- Think about groups or individuals you already know.
- Who have you successfully collaborated with in the past?
- Shape a collective identity tied to the goal of reducing mental health or substance abuse problems or trauma in your community.
- Talk about roles and responsibilities of the coalition up front, and immediately acknowledge and address turf issues.
- Re-examine your process for decisionmaking and shared rules of engagement.
- Celebrate success.

C. Planning: Developing a Strategic Plan

The planning you do now will provide the foundation for your entire program. Planning involves identifying your goals and objectives and then determining your strategies and activities for moving forward.

PLANNING CHECKLIST

- Identify your goals, objectives, and strategies.
- Design or select your activities.
- Create a logic model that explains, visually, how the program activities will meet your goals and objectives.
- Establish timelines for implementation.
- Review the details of implementation and compare them to your budget; identify resources available and training needs.
- Identify the barriers to your implementation plan, and make a plan to address these barriers.
- Review the program materials and logic model and make any adaptations that will be needed within your own community setting to fit in with the culture of the community.
- Establish a plan for process evaluation.

Source: Adapted from SAMHSA (2010).

Identify Your Goals and Objectives

Before coming up with activities you want to accomplish through your program, it is important to first identify both your program goals and your objectives.

Program goals are the major behavior changes that you hope to see in your populations of focus. While program goals often take a long time to achieve, objectives are the short-term and intermediate changes in (1) awareness, (2) attitudes, and (3) smaller behaviors that lead to the major behavior changes you hope to see. Both program goals and objectives should be measurable. The following table gives some examples of program goals and objectives.

Again, these are just some examples. You should choose objectives that fit your community's specific needs.

EXAMPLES OF PROGRAM GOALS AND OBJECTIVES	
Program goal	**Possible program objectives**
• A measurable reduction in child abuse rates	• An improvement in parenting practices and behaviors • The strengthening of community services systems (formal supports) • An improvement in a community's capacity to protect children and support parents (informal supports)
• A measurable increase in numbers of depressed caregivers who obtain treatment	• An increase in the number of people who recognize the symptoms of depression and think it is OK to seek help • An increase in the number of OB/GYNS who regularly screen for depression and anxiety
• A measurable increase in numbers of children in domestic violence situations who are assessed for potential trauma	• An increase in the number of police personnel who are trained to recognize the signs and symptoms of trauma in young children • An increase in number of early childcare workers who are trained to recognize the signs and symptoms of trauma in young children • An increase in the general public's awareness that witnessing violence can have negative effects on young children

Designing and Adapting Programs for Culturally Diverse Families

Before planning your program or activities, it is important to think about the cultural context and readiness of your population of focus, the values and traditions that affect how your identified group regards health promotion issues, and the extent to which the community is ready for the program. Programs and approaches that work for some populations may seem irrelevant or even threatening to others. Keep this in mind as you develop your program to help ensure that you come up with strategies and activities that resonate with the community. This will enable you to design programs that feel relevant, meaningful, and safe to the people you are trying to reach.

Determine Your Strategies

While goals and objectives identify what you hope to accomplish, strategies are the ways in which you hope to accomplish them. Strategies may include mass media campaigns, advocacy efforts, public education, or partnership building. These are just some examples. You can select multiple strategies to address your goals and objectives.

Once you've identified your strategies, determine the activities you will undertake to meet your goals and objectives. These activities should correspond to the strategies you've selected. For example, if your goal is to increase the number of women who are screened for postpartum depression, you have several strategies to choose from to accomplish this. One strategy might be public education. If you have the capacity, you might

choose to air a public service announcement on the local radio station describing postpartum depression, the risks it can pose for a family, and where to get help.

You could also choose to use public advocacy to support laws that increase the chances that new mothers will be screened. This strategy was used successfully in New Jersey and resulted in legislation that mandates that health care professionals educate and screen new mothers for postpartum depression, making it the first State in the nation to do so. For more information on postpartum depression and the legislative efforts in New Jersey, see http://www.state.nj.us/health/fhs/postpartumdepression/index.shtml. In order to be successful at legislative endeavors, you will need to use the strategy of partnership building. Your activities may include bringing together a coalition of community stakeholders and planning regular meetings.

If you're not sure where to start, the good news is that you don't have to come up with activities from scratch. A wide range of programs designed to build resiliency and support families exist in communities around the country—and maybe even within your own community. In addition to the programs highlighted in this Guide, go to SAMHSA's National Registry of Evidence-based Programs and Practices at http://nrepp.samhsa.gov to see several more examples of effective programs. Determine how these programs fit in with what you are trying to accomplish. Gather enough detail on programs or activities that best fit your goals and objectives to find out how well they can be adapted to your community, what the costs of the program materials and training will be, and what the costs of the adaptation will be. Ask yourself:

- Do they serve the same population?
- Are they complementary to your program? If the program is in your community, would you be competing for the same population?
- What are the risk and protective factors that the programs target?
- What cultural settings have they been adapted to fit within?
- Who are the key players and leaders in these programs?
- What kinds of outcomes do these programs have?

Remember, as you develop your program or activities, keep in mind the cultural context and readiness of your population of focus. Take time to learn about the shared values, ideas, and beliefs in which your population of focus lives to help ensure that you design programs that feel relevant, meaningful, and safe to the people you are trying to reach.

Plan Your Internal Process

Once you have selected your activities, develop a plan that guides your internal process—how your activities will be carried out on a day-to-day basis. Before launching your action plan, consider creating a spreadsheet to track specific tasks. Include a description of each task, the person responsible for completing the task, and

the deadline for each task. Keep track of when each task is completed. This will enable you to more readily evaluate whether components of your action plan are being carried out effectively.

D. Implementation: Getting to Action

Your work so far brings you to the process of implementing your selected action plan.

Implementation involves:

- Launching your action plan and carrying it out;
- Keeping track of how your effort is being delivered through process evaluation; and
- Making adjustments along the way.

Launching Your Action Plan

A launch is how you will kick off your action plan. You may choose to launch your program slowly on a limited basis by conducting an activity in one geographic area to test the program. Using a limited approach will permit you to make adjustments before you fully commit your resources. Or you may choose to launch with a highly visible kickoff event, such as a press conference. Before you launch your program, make sure to develop a launch plan outlining what you will do and when. Also be sure to prepare your staff for the work ahead.

Process Evaluation

Good implementation involves much more than simply carrying out the components of your action plan. It means that you will need to keep track of how your activity is delivered, also known as process evaluation. Process evaluation monitors the functioning of program components. It includes assessment of whether messages are being delivered appropriately, effectively, and efficiently; whether materials are being distributed to the right people and in the right quantities; whether the intended program activities are occurring; whether people are using materials correctly and consistently; whether the people you serve are consistently participating in or receiving the necessary services; and other measures of how well the program is working. Use process evaluation to track the following:

- Partner or coalition involvement;
- The effectiveness of publicity, promotion, and other outreach efforts;
- Media response;
- Intended community participation, inquiries, and other responses;
- Expenditures and adherence to budget;
- How staff members are carrying out their assigned tasks;
- Whether deadlines are being met; and
- Environmental factors that are inhibiting or promoting project success.

Develop your process evaluation plan before you launch your program. This will enable you to act quickly if adjustments need to be made.

Examples of Process Evaluation Measures

Dissemination—

- Quantities of educational materials distributed
- Number of presentations given
- Number of special events
- Size of audiences at presentations and events

Response—

- Number of telephone, mail, and e-mail inquiries (how people heard of the program, what they asked about it)
- Number of people visiting Web sites
- Number of organizations, businesses, or media outlets participating in the program
- Response to presentations (measured by completed participant feedback forms)
- Number of publications requested and distributed

Audience—

- Demographic or other characteristics of the responding audience (to find out whether the intended audience responded)
- Number of people visiting Web sites
- Number of organizations, businesses, or media outlets participating in the program
- Response to presentations (measured by completed participant feedback forms)
- Number of publications requested and distributed

Making Adjustments

The implementation stage will not always proceed as you expect. A new priority may delay community participation, the site you planned on using may become problematic, or a major news story may preempt your publicity (or focus additional attention on your issue). A periodic review of your planned tasks and time schedules will help you revise any plans that might be affected by unexpected events or delays.

E. Evaluation: Measuring Outcomes

Outcome evaluation is important because it shows how well the program has met its objectives and what you might change to make it more effective. Learning how well the program has met its objectives is vital for:

- Justifying the program to agency management and leaders;
- Providing evidence of success or the need for additional resources;
- Increasing organizational understanding of and support for the program;
- Encouraging ongoing partnerships with other organizations; and
- Adjusting approaches that aren't producing intended results.

Evaluation Constraints

Even on a limited budget, communities can evaluate their efforts. Keep in mind that every program planner faces obstacles when conducting an outcome evaluation, such as the following:

- Limited funding;
- Limited staff time or expertise;
- Length of time allotted to the program and its evaluation;
- Restrictions on hiring consultants or contractors;
- Policies that limit the ability to collect information from the public; or
- Difficulty in isolating program effects from other influences on the intended audience in "real world" situations.

Think about whether these limitations apply to your community. If they do, and if conducting a large-scale evaluation is unrealistic, you still have the option of evaluating outcomes on a smaller scale. The following sections will help you get started.

How to Evaluate Your Program

To determine changes in awareness, attitudes, and behaviors, you will need to collect data.

It is essential that you think about what data you want to collect early in the planning process. For most projects, collect data at the beginning and end of your program in order to see what progress was made. Have the evaluation process spelled out long before the program is implemented.

Define the data you need to collect. Determine what you can and should measure to assess progress on meeting objectives. Depending on your project, some of the following questions may be used as a guide:

- Did awareness of the problem increase in the community?
- Did attitudes about the problem change?
- Did the community take action?
- Did awareness of the program name, message, or logo increase?
- Were policies initiated or other institutional actions taken?
- Did caregivers experiencing mental health or substance abuse problems feel more support from families and communities?

Decide on data collection methods. Most outcome evaluation methods involve collecting data about participants through observation or a questionnaire. Select a method that allows you to best answer your evaluation questions based upon your access to your populations of focus and your resources. Seek help to decide what type of evaluation will best serve your program, if possible. Sources include university faculty and graduate students (for data collection and analysis), local businesses (for staff and computer time), State and local health agencies, and consultants and organizations with evaluation expertise.

Develop or locate data collection instruments. Many data collection instruments already exist, so you may not need to develop something new. Research existing instruments, measures, resources, and other sources of help. These may include tally sheets for counting public inquiries, survey questionnaires, or interview guides. Use instruments that are valid, reliable, and, whenever possible, have been used with the population of people you are serving.

You may find that it is necessary to develop a new data collection instrument or adapt an existing one. If this is the case, consider contacting a professional evaluator for guidance.

Collect, process, and analyze the data. It is important to collect data throughout your program or activity.

Use statistical techniques as appropriate to discover significant relationships. Your program might consider involving university-based evaluators, providing them with an opportunity for publication and your program with evaluation expertise. Results will vary depending on the program, the issue, and the intended audience. Don't expect instant results; creating and sustaining change in behavior takes time and commitment. Your program may show shorter-term, activity-related results when you conduct your process evaluation; these changes in knowledge, information-seeking, and skills may occur sooner than more complex behavioral changes.

The United Way of America has developed a helpful step-by-step manual on evaluating programs that is used by thousands of nonprofit organizations. For a copy of this manual, go to http://www.unitedwaystore.com/product/measuring_program_outcomes_a_practical_approach/program_film. Another good resource for evaluation manuals is the Center for Disease Control's Web site: http://www.cdc.gov/eval/resources/index.htm. For issues related to evaluating community-level change, see The Annie E. Casey Foundation's report on *Evaluating Comprehensive Community Change* at http://www.aecf.org/upload/publicationfiles/community%20change.pdf.

Refining Your Program

The program planning process is circular. The end of evaluation is not the end of the process but the step that takes you back to the beginning. Review the evaluation results and consider the following questions to help you identify areas of the program that should be changed, deleted, or augmented.

Goals and objectives—

- Have your goals and objectives shifted as you've conducted the program?
- Are there objectives the program is not meeting? Why?
- What are the barriers you are encountering?
- Has the program met some of your objectives, or does it seem not to be working at all?

Where additional effort may be needed—

- Is there new health information that should be incorporated into the program's messages or design?
- Are there strategies or activities that did not succeed?

Implications of success—

- Which objectives have been met, and by what successful activities?
- Should successful activities be continued and strengthened because they appear to work well or should they be considered successful and completed?

- Can successful activities be expanded to apply to other populations or situations?

Costs and results of different activities—

- What were the costs (including staff time) and results of different aspects of the program?
- Do some activities appear to work as well as, but cost less than, others?

Accountability—

- Is there evidence of program effectiveness and of a continued need to persuade your organization to continue the program?
- Have you shared the results of your activities with the leadership of your organization?
- Have you shared results with partners?
- Do the assessment results show a need for new activities that would require partnerships with additional organizations?

Once you have answered all of these questions, you may realize that only simple changes need to be made. You also may find that you need to return to the strategic planning framework to help rewrite and revise your program plan to accommodate new approaches, new tasks, and new timelines. Even if major changes need to be made, don't stop now—you have learned many invaluable lessons from your first effort.

Adapted from: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Division of Nutrition and Physical Activity (1999), Promoting Physical Activity: A Guide for Community Action. Human Kinetics: Champaign, IL.

SECTION 5:

MOVING FORWARD

Every family in every community needs good information, concrete resources, and consistent support to thrive. For those families who have the additional challenges of trauma, mental health problems, or substance abuse, the need for these resources and supports is crucial. In the words of Dr. Gary Melton from Strong Families, the goal of the responsive community is "for every child and every parent to be confident that someone will notice and someone will care whenever they have cause for joy, sorrow, or worry."

We know much more about how early experiences shape the developing child than we did even a decade ago. Our task is to take that knowledge and use it in a thoughtful way to raise awareness, develop initiatives, create programs, and pursue legislation that will get us closer to that day when every community and every family will have the supports necessary for healthy children. Remember that your efforts do make a difference!

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ENDNOTES

1. To download the book for free and listen to podcasts based on it, go to http://www.nap.edu/catalog.php?record_id=9824#toc.

2. Cortisol levels in physically abused children are often significantly higher than normal, while cortisol levels in neglected children are often significantly lower. Both lead to adverse outcomes (Gunnar, Talge, and Herrera, 2009).

3. For a review of these studies, see Hildyard and Wolfe (2002) and English et al. (2005).

APPENDIX A: ACKNOWLEDGMENTS

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APPENDIX B : RESOURCE LIST

ORGANIZATIONS

The following is a list of national organizations that promote the well-being of children, families, and communities by promoting protective factors or addressing child maltreatment. Many of these organizations have member agencies and can link you to local affiliates in your State or community. More information about national organizations that work to strengthen families and communities is available on the Child Welfare Information Gateway Web site at http://www.childwelfare.gov/.

American Academy of Pediatrics is committed to the attainment of optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. The Section on Child Abuse and Neglect provides an educational forum for the discussion of problems and treatments related to child abuse and neglect and its prevention: **http://www.aap.org**.

American Humane Association assists professionals and citizens in making informed decisions about how to help children and families in crisis. The association also develops resources and programs that help child welfare systems deliver quality services and communities and citizens prevent child abuse: **http://www.americanhumane.org**.

American Professional Society on the Abuse of Children seeks to improve the quality of practice provided by professionals who work in child abuse and neglect by providing professional education and promoting research and practice guidelines in child maltreatment: **http://www.apsac.org**.

Annie E. Casey Foundation works to build better futures for disadvantaged children and their families in the United States. The Foundation's mission is to foster public policies, human service reforms, and community supports that more effectively meet the needs of today's vulnerable children and families: **http://www.aecf.org**.

Asian & Pacific Islander Institute on Domestic Violence is a national training and technical assistance provider and a clearinghouse on gender violence in Asian, Native Hawaiian, and Pacific Islander communities: **http://www.apiidv.org.**

AVANCE Family Support and Education Program operates a national training center to share and disseminate information, material, and curricula to service providers and policymakers interested in supporting high-risk Hispanic families: **http://www.avance.org**.

Center for the Study of Social Policy develops public policies and practices that strengthen families and communities. CSSP is the coordinator of the national Strengthening Families initiative, which is working in over half of all States to engage early childhood providers and others that see children on a day-to-day basis in building protective factors: **http://www.cssp.org**.

Chapin Hall Center for Children at the University of Chicago is a policy research center dedicated to bringing rigorous research and innovative ideas to policymakers, service providers, and funders working to improve the well-being of children. Its work provides a source of knowledge about the needs of children and the service systems designed to meet those needs: **http://www.chapinhall.org**.

Childhelp directly serves abused children through residential treatment facilities, child advocacy centers, group homes, foster care, preschool programs, child abuse prevention programs, and community outreach: **http://www.childhelp.org**.

Child Welfare Information Gateway, a service of the Children's Bureau, promotes the safety, permanency, and well-being of children and families by connecting child welfare, adoption, and related professionals, as well as concerned citizens, to timely, essential information: **http://www.childwelfare.gov**. The Prevention page, **http://www.childwelfare.gov/preventing/preventionmonth**, includes a community resource guide that is created every year for use during April, child abuse prevention month.

Child Welfare League of America is an association of more than 800 public and private nonprofit agencies that assist over 3.5 million abused and neglected children and their families each year with a wide range of services: **http://www.cwla.org**.

Circle of Parents, a national network of parents and statewide and regional organizations, works to prevent child abuse and neglect, strengthen families, and promote parent leadership through mutual self-help parent support groups and children's programs: **http://www.circleofparents.org**.

Doris Duke Charitable Foundation child abuse prevention program supports a small number of national organizations and research initiatives that advance efforts to prevent the maltreatment of young children by providing services, supports, and information to families: **http://www.ddcf.org**.

FRIENDS National Resource Center for Community-Based Child Abuse Prevention, a service of the Children's Bureau, provides information, training, and technical assistance to Federal grantee agencies implementing the Community-Based Grants for the Prevention of Child Abuse and Neglect, under the Keeping Children and Families Safe Act of 2003. FRIENDS is committed to building the capacity of State Community-Based Child Abuse Prevention Lead Agencies to prevent child abuse and neglect and to strengthen and support families: **http://www.friendsnrc.org**.

Futures Without Violence, formerly The Family Violence Prevention Fund, works to prevent and end violence against women and children around the world: **http://www.futureswithoutviolence.org.**

Institute on Domestic Violence in the African American Community focuses on the unique circumstances and life experiences of African Americans as they seek resources and remedies related to the victimization and perpetration of domestic violence in their community: **http://www.dvinstitute.org.**

National Alliance of Children's Trust and Prevention Funds assists State- and local-level affiliates to build and maintain a system of services, laws, practices, and attitudes that strengthen families and prevent child abuse and neglect, achieved by assisting Children's Trust and Prevention Funds at the State and national levels: **http://www.ctfalliance.org**.

National Association of Children's Hospitals and Related Institutions (NACHRI) promotes the health and well-being of all children and their families through support of children's hospitals and health systems that are committed to excellence in providing health care to children: **http://www.childrenshospitals.net**.

National Association for the Education of Young Children provides leadership and consolidation of efforts of individuals and groups working to achieve healthy development and constructive education for all young children: **http://www.naeyc.org**.

National Center for Children in Poverty uses research to inform policy and practice with the goal of promoting the economic security, health, and well-being of America's low-income families and children: **http://www.nccp.org**.

National Center on Domestic Violence, Trauma & Mental Health is committed to developing comprehensive, accessible, and culturally relevant responses to the range of trauma-related issues faced by domestic violence survivors and their children; to promoting advocacy that is survivor-defined and rooted in principles of social justice; and to eradicating the social and psychological conditions that contribute to interpersonal abuse and violence across the lifespan: **http://www.nationalcenterdvtraumamh.org**.

National Center on Shaken Baby Syndrome prevents shaken baby syndrome through the development and implementation of education, programs, public policy, and research to establish networks for, support, and train families, caregivers, and professionals: **http://www.dontshake.org**.

National Children's Advocacy Center provides prevention, intervention, and treatment services to physically and sexually abused children and their families within a child-focused team approach: **http://www.nationalcac.org**.

National Children's Alliance is a nonprofit organization whose mission is to provide training, technical assistance, and networking opportunities to communities seeking to plan, establish, and improve children's advocacy centers: **http://www.nca-online.org**.

The National Child Traumatic Stress Network, which is funded by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services, comprises more than 50 centers nationwide that provide treatment and services to traumatized children and their families: **http://www.nctsnet.org/nccts**.

National Child Welfare Resource Center for Family-Centered Practice helps child welfare agencies and tribes use family-centered practice to implement the tenets of the Adoption and Safe Families Act to ensure the safety and well-being of children while meeting the needs of families: **http://www.uiowa.edu/~nrcfcp/**.

National Coalition against Domestic Violence supports the provision of safe houses and shelter programs for battered women and their children; assists in coalition-building at the local, State, regional, and national levels; provides public education, technical assistance, and policy development; and promotes efforts to eradicate social conditions that contribute to violence against women and children: **http://www.ncadv.org**.

National Exchange Club Child Abuse Prevention Services coordinates a nationwide network of nearly 100 Exchange Club Child Abuse Prevention Centers that use the parent aide program and provide support to families at risk for abuse: **http://www.preventchildabuse.com**.

National Family Preservation Network provides training, tools, and resources to assist policymakers and practitioners to build on a family's strengths and to preserve family bonds so that children can be protected and nurtured at home: **http://www.nfpn.org**.

National Fatherhood Initiative works to improve the well-being of children by increasing the proportion of children growing up with involved, responsible, and committed fathers: **http://www.fatherhood.org**.

National Implementation Research Network works to close the gap between science and service by improving the science and practice of implementation in relation to evidence-based programs and practices: **http://nirn.fpg.unc.edu/**.

National Indian Child Welfare Association is a membership organization of tribes, individuals, and private organizations that work to promote American Indian child welfare and address child abuse and neglect through training, research, public policy, and grassroots community development: **http://www.nicwa.org**.

National Latin@ Network for Healthy Families and Communities exists to advance effective responses to eliminate violence and promote healthy relationships within Latin@ families and communities: **http://www.casadeesperanza.org**.

National Resource Center on Child Maltreatment helps states, local agencies, and tribes develop effective and efficient child protective services systems. Jointly operated by the Child Welfare Institute and ACTION for Child Protection, it responds to needs related to prevention, identification, intervention, and treatment of child abuse and neglect: **http://www.gocwi.org/**.

National Resource Center on Domestic Violence supports organizations and individuals working to end domestic violence through training, technical assistance, and dissemination of information on relevant issues: **http://www.nrcdv.org**.

National Respite Coalition secures quality, accessible, planned, and crisis respite services for all families and caregivers in need of such services in order to strengthen and stabilize families and enhance child and adult safety: **http://archrespite.org/national-respite-coalition**.

National Responsible Fatherhood Clearinghouse serves as a central source for professionals and the public to learn more about the importance of responsible fatherhood and fatherhood issues: **http://www.fatherhood.gov**.

Nurse-Family Partnership supports communities in implementing a cost-effective, evidence-based nurse home visitation program to improve pregnancy outcomes, child health and development, and self-sufficiency for eligible, first-time parents—benefiting multiple generations: **http://www.nursefamilypartnership.org**.

Parents Anonymous, Inc. is a community of parents, organizations, and volunteers committed to strengthening families and building strong communities, achieving meaningful parent leadership and shared leadership, and leading the field of child abuse and neglect prevention: **http://www.parentsanonymous.org**.

Prevent Child Abuse America provides leadership to promote and implement national and local prevention efforts: **http://www.preventchildabuse.org**.

Resource Center on Domestic Violence: Child Protection & Custody is part of the National Council of Juvenile and Family Court Judges' (NCJFCJ) Family Violence Department and provides information and tangible assistance to those working in the field of domestic violence and child protection and custody. The Center provides technical assistance, training, policy development, and other resources that increase safety, promote stability, and enhance the well-being of battered parents and their children: **http://www.ncjfcj.org**.

Search Institute conducts research to identify what children and adolescents need to become caring, healthy, and responsible adults and provides resources to apply this knowledge and to motivate and equip others in ensuring that young people are valued and thrive: **http://www.search-institute.org**.

ZERO TO THREE disseminates key developmental information, trains providers, promotes model approaches and standards of practice, and works to increase public awareness about the significance of the first 3 years of life: **http://www.zerotothree.org**.

MENTAL HEALTH

The following organizations focus on the needs of parents who are struggling with mental health problems.

The American Psychological Association is a scientific and professional organization that represents the field of psychology in the United States. With 150,000 members, The American Psychological Association (APA) is the largest association of psychologists worldwide. APA's mission is to advance the creation, communication, and application of psychological knowledge to benefit society and improve people's lives: **http://www.apa.org**.

Brazelton Touchpoints Center ® is dedicated to strengthening the systems of care that serve young children and their families. Founded upon the research and practice of pediatrician T. Berry Brazelton, MD, the Center provides knowledge development, professional development and training, technical assistance, and collaborative consultation in communities where professionals serving families of young children have made a commitment to forming empowering partnerships with them: **http://www.touchpoints.org/about-us.html**.

Family Mental Health Institute focuses on four areas to reduce the incidence of maternal depression and mental health disparities in women: screening programs for early postpartum depression detection, professional education and training, public education, and peer support groups for women and their families: **http://www.promoteprevent.org/resources/family-mental-health-institutes-ppd-hope™-information-center-web-site**.

Maternal and Child Health Bureau is a division of the Health Resources and Services Administration, U.S. Department of Health and Human Services, and promotes an environment that supports maternal and child health, including eliminating health barriers and disparities, improving the health infrastructure and systems of care, and assuring quality of care. Maternal and Child Health Bureau resources and initiatives related to perinatal depression include *Perinatal Depression: Emerging Perspectives and Practice*s, which includes an agenda, speakers' materials, and links to additional resources related to an MCH DataSpeak audioconference about perinatal depression: **http://www.mchb.hrsa.gov**.

Mental Health America advocates for changes in policy related to mental health issues, educates the public about mental illness, and sponsors the and delivers programs and services through more than 300 affiliates across the country: **http://www.nmha.org**. Mental Health America also sponsors National Depression Screening Day: **http://www.nmha.org/go/depression-screening-day**.

Mothers and Others is a Web site developed with the support of the National Institute of Mental Health to provide education about postpartum depression: **http://www.mededppd.org/mothers**.

National Alliance on Mental Illness offers education and training programs for consumers, family members, providers, and the general public and has 1,200 affiliate organizations throughout the United States: **http://www.nami.org**.

National Center for Health Statistics provides statistical information that will guide actions and policies to improve the health of the American people: **http://www.cdc.gov/nchs**.

National Federation of Families for Children's Mental Health serves to provide advocacy at the national level for the rights of children and youth with emotional, behavioral, and mental health challenges and their families. The National Federation also collaborates with other child-serving organizations to transform mental health care in the United States: **http://www.ffcmh.org**.

National Healthy Mothers, Healthy Babies Coalition aims to improve the health and safety of mothers, babies, and families through educational materials and partnerships: **http://www.hmhb.org**.

National Institute of Mental Health, of the National Institute of Health, provides research information and publications for health professionals and consumers about research, clinical trials, funding opportunities, and training on mental health issues: **http://www.nimh.nih.gov**.

The National Association of State Mental Health Program Directors represents the $34 billion public mental health service delivery system serving 6.3 million people annually in all 50 states, 4 territories, and the District of Columbia. The National Association of State Mental Health Program Directors operates under a cooperative agreement with the National Governors Association and is the only national association to represent state mental health commissioners and directors and their agencies: **http://www.nasmhpd.org/About/about.aspx**.

National Women's Health Information Center is a service of the U.S. Department of Health and Human Services and offers a variety of women's health information online, including a fact sheet about depression during and after pregnancy and links to resources on the topic: **http://www.womenshealth.gov**.

Perinatal Foundation works in partnership with the Wisconsin Association for Perinatal Care to improve the health of infants, mothers, and families from preconception to early childhood: **http://www.perinatalweb.org**.

Postpartum Education for Parents is a nonprofit corporation staffed entirely by volunteers, all of whom have been trained to provide answers and act as objective, nonjudgmental listeners: **http://www.sbpep.org**.

Postpartum Support International is an international network of women, their families, and professionals that focuses on postpartum mental health and social support: **http://www.postpartum.net**.

Substance Abuse and Mental Health Services Administration provides national leadership to ensure the application of scientifically established findings and practice-based knowledge in the prevention and treatment of mental health and substance use disorders; to improve access, reduce barriers, and promote high-quality effective programs and services for people with, or at risk for, these disorders, as well as for their families and communities; and to promote an improved state of mental health within the nation, as well as the rehabilitation of people with mental health and substance use disorders: **http://www.samhsa.gov**.

Additional Resources from Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA's National Registry of Evidence-based Programs and Practices. A searchable database of interventions for the prevention and treatment of mental health and substance use disorders. **http://www.nrepp.samhsa.gov**.

Find Substance Use and Mental Health Treatment: **http://www.samhsa.gov/treatment/**.
SAMHSA Prevention Platform: http://www.samhsa.gov/.

SAMHSA Suicide Prevention Resources: http://www.samhsa.gov/matrix2/matrix_suicide.

SUBSTANCE ABUSE

The following organizations or Web sites focus on the needs of parents and other caregivers who struggle with drug abuse or addiction, and the impact of these issues on the family.

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover from alcoholism: **http://www.aa.org**.

AddictionAction.org is a grassroots partnership to help communities mobilize around it, bringing the hope of treatment and long-term recovery to individuals and families affected by addiction to alcohol and drugs: **http://www.addictionaction.org**.

Addiction Project is a multimedia campaign, produced by HBO in partnership with the Robert Wood Johnson Foundation, the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA): **http://www.hbo.com/addiction**.

Addiction Treatment Forum is an educational site focusing on addiction issues, especially opiate addiction and treatment: **http://www.atforum.com**.

Community Anti-Drug Coalitions of America trains local grassroots groups, known as community anti-drug coalitions, in effective community problem-solving strategies, teaching them how to assess their local substance abuse-related problems and develop a comprehensive plan to address them. Today, Community Anti-Drug Coalitions of America is one of the nation's leading drug abuse prevention organizations, representing the interests of more than 5,000 community anti-drug coalitions in the country: **http://www.cadca.org**.

Center for Chemical Addiction Treatment offers a variety of programs for chemical addiction, such as Medically Monitored Detoxification; Pre-Treatment; Short-Term Residential; Older Adults Seeking Independence in Sobriety; Continuing Care; Family Programs; and Opiate Recovery Program: **http://www.ccatsober.org**.

SAMHSA's Center for Substance Abuse Prevention works with States and communities to develop comprehensive prevention systems that create healthy communities in which people enjoy a quality life. This includes supportive work and school environments, drug- and crime-free neighborhoods, and positive connections with friends and family: **http://www.samhsa.gov/about/csap.aspx**.

SAMHSA's Center for Substance Abuse Treatment promotes the quality and availability of community-based substance abuse treatment services for individuals and families who need them. Center for Substance Abuse Treatment works with States and community-based groups to improve and expand existing substance abuse treatment services and supports SAMHSA's free treatment referral service to link people with the community-based substance abuse services they need: **http://www.samhsa.gov/about/csat.aspx.**

Cocaine Anonymous is a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover from their addiction: **http://www.ca.org**.

Drug-Free Action Alliance encourages all segments of a community throughout the country to become involved in the planning, implementation, and recognition of the importance of being alcohol, tobacco, and other drug free. The newly redesigned Web site, **http://www.DrugFree24-7.org**, serves as a resource for schools, businesses, and community groups to implement substance abuse prevention activities throughout the year: **http://www.drugfreeactionalliance.org**.

Faces and Voices of Recovery promotes public policy initiatives that support recovery from alcohol and drug abuse by fostering advocacy skills in individuals recovering from addiction problems. The Alliance Project of Faces and Voices finds ways to inform the medical, public health, criminal justice, and other communities about the possibilities of recovery from addiction to alcohol and other drugs: **http://www.facesandvoicesofrecovery.org**.

Join Together helps community leaders understand and use the most current scientifically valid prevention and treatment approaches to advance effective alcohol and drug policy, prevention, and treatment: **http://www.drugfree.org/join-together**.

Methadone Anonymous sponsors a Web site that answers questions about methadone abuse: **http://www.methadonesupport.org**.

Narcotics Anonymous offers addicts a way to live drug-free: **http://www.na.org**.

National Association of State Alcohol and Drug Abuse Directors, Inc. is a private, nonprofit educational, scientific, and informational organization that serves State drug agency Directors and State alcoholism agency Directors to support the development of effective alcohol and other drug abuse prevention and treatment programs throughout every State: **http://www.nasadad.org**.

National Center on Addiction and Substance Abuse at Columbia University provides information on the cost of substance abuse throughout society and its impact on lives: **http://www.casacolumbia.org**.

National Center on Substance Abuse and Child Welfare, funded by Administration for Children & Families and SAMHSA, strives to improve systems and practice for families with substance use disorders who are involved in the child welfare and family judicial systems by assisting local, State, and tribal agencies: **http://www.ncsacw.samhsa.gov**.

National Council on Alcoholism and Drug Dependence Inc. provides education, information, and support in the fight against substance abuse: **http://www.ncadd.org**.

National Institute on Drug Abuse of the National Institute of Health provides the latest scientific information on drug abuse and addiction: **http://www.nida.nih.gov**.

Network for the Improvement of Addiction Treatment is a partnership between the Robert Wood Johnson Foundation's Paths to Recovery program, the Center for Substance Abuse Treatment's Strengthening Treatment Access and Retention program, and a number of independent treatment organizations: **https://www.niatx.net/Content/ContentPage.aspx?NID=9**.

Partnership for a Drug Free America unites parents, scientists, and communications professionals to help families raise healthy children: **http://www.drugfree.org**.

Substance Abuse and Mental Health Services Administration (SAMHSA) provides a national database of evidence-based programs and practices for prevention and treatment of mental and substance use disorders: **http://www.nrepp.samhsa.gov**. See the previous section for more information and resources from SAMHSA.

Treatment Research Institute disseminates evidence-based information on the treatment of substance abuse: **http://tresearch.org**.

WARMLINES AND HOTLINES

Family Mental Health Institute Warmline: Women and their families affected by postpartum depression who contact the warmline will receive a call back from a mother who has experience dealing with and recovering from postpartum depression. The warmline also provides printed information and suggestions for whom to contact for additional assistance.
1 (877) PPD–HOPE (773–4673)

Maternal and Child Health Bureau Warmline: Designed to help pregnant women and mothers with newborns identify free or low-cost services for themselves and their infants in their communities.
1 (800) 311–BABY (2229)
1 (800) 504–7081 (Spanish)

National Child Abuse Hotline: The Childhelp National Child Abuse Hotline is open 24 hours a day, 7 days a week. The hotline counselors work with translators who speak 140 languages to help people who call and speak something other than English. All calls are anonymous.
1 (800) 4–A–CHILD

National Dating Abuse Helpline (formerly the National Teen Dating Abuse Helpline): This national, 24-hour resource is specifically designed for teens and young adults. The Helpline offers real-time, one-on-one support from peer advocates. Training is offered to young leaders to provide support, information and advocacy to those involved in dating abuse relationships as well as to concerned friends, parents, teachers, clergy, law enforcement and service providers.
1 (866) 331-9474

National Domestic Violence Hotline: The National Domestic Violence Hotline is open 24 hours a day, 7 days a week and provides crisis intervention information and referral to victims of domestic violence, perpetrators, friends, and families.
1 (800) 799–SAFE (7233)
1 (800) 787–3224 (TTY)

National Suicide Prevention Lifeline: This free and confidential service aids those who feel like there is nowhere to turn. Can be dialed toll-free from anywhere in the United States 24 hours a day, 7 days a week. Trained crisis center staff offer crisis counseling, suicide intervention, and referral information.
1 (800) 273–TALK (8255)
1 (888) 628–9454 (Spanish)

Parents Educating Parents Warmline: Free 24-hour service provides confidential one-on-one support from other parents who are trained volunteers. From basic infant care to breast- or bottle-feeding issues to postpartum adjustment, the warmline can be a great source of information and support.
1 (805) 564–3888

Postpartum Support International's Postpartum Depression Helpline: Callers will receive immediate support and information or a return call in English or Spanish, as well as referrals to local services.
1 (800) 944–4PPD (4773)

APPENDIX C: SCREENING TOOLS

DEPRESSION

Beck Depression Inventory®–II (BDI®–II)
Number of questions: 21-item self-report
Recommended use: Recommended for primary care clinics delivering perinatal care
Notes: Screens for general depression. Available in English, Japanese, and Spanish.

Center for Epidemiological Studies-Depression Scale (CES-D)
Number of questions: 20-item self-report
Recommended use: Epidemiologic and community studies
Notes: Screens for general and PPD depression.

Edinburgh Postnatal Depression Scale (EPDS)
Number of questions: 10-item self-report
Recommended use: Obstetric clinics, doulas, and pediatric clinics
Notes: Specifically designed for detecting postnatal depression. Used in 23 countries and available in English and Spanish.

Patient Health Questionnaire (PHQ-9)
Number of questions: 9-item self-report
Recommended use: Primary care clinics delivering perinatal care
Notes: Linked to Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), tracks response to treatment.

Postpartum Depression Screening Scale (PDSS)
Number of questions: 35-item self-report, Likert-scale
Recommended use: Psychotherapists and counselors
Notes: Developed for PPD in particular.

ALCOHOL ABUSE

Michigan Alcohol Screening Test (MAST)
Number of questions: 22 self-report
Available from National Council on Alcoholism and Drug Dependence:
http://bhcs-support.com/MichiganAlcoholTest.

The CAGE Questionnaire (CAGE)
Number of questions: 4 self-report
Available from National Institute on Alcohol Abuse and Alcoholism:
www.pubs.niaaa.nih.gov/publications/arh28-2/78-79.htm.

The T-ACE Questionnaire (for pregnant women)
Number of questions: 4
Available from National Institute on Alcohol Abuse and Alcoholism:
http://pubs.niaaa.nih.gov/publications/arh25-3/204-209.htm .

The TWEAK Questionnaire (for pregnant women)
Number of questions: 5
Available from National Institute on Alcohol Abuse and Alcoholism:
http://alcoholism.about.com/od/tests/a/tweak.htm .

DRUG ABUSE (NOT INCLUDING ALCOHOL)

Drug Abuse Screening Test (DAST)
Number of questions: 28
Available from Project Cork:
www.projectcork.org/clinical_tools/html/DAST.html.

APPENDIX D: ASSESSING THE PROBLEM

20 QUESTIONS TO CONSIDER

Scope of the Problem

1. What is the incidence or prevalence of the target issue in your community?

2. Who is affected by the problem (including age, sex, race/ethnicity, economic situation, educational or reading level, place of work and residence)? What are the risk and protective factors for those affected?

3. What is the impact of the target issue in your community? What are the effects on individuals and the larger community?

4. How and by whom is the problem already being addressed? For example, is the local health department focusing on child abuse or neglect? Is there a local affiliate of a national organization that focuses on maternal depression?

5. What happens to a caregiver who needs treatment for mental health or substance abuse problems, or for trauma that he or she might have experienced? Where can he or she get treatment? What kind of treatment? How do community mental health centers respond? Does the typical protocol include questions about parenting issues or how well children are doing?

Community Awareness

6. Has there ever been a public awareness campaign focusing on your issue of concern? What was the impact? Did the campaign include attention to low-income communities? Were there culturally and linguistically responsive efforts?

Treatment Issues

7. If you are addressing treatment issues, what are the barriers to accessing treatment for those affected?

8. What approach or combination of approaches can best engage caregivers to participate in your program, initiative, or treatment effort?

9. Are there home-visiting programs in the community that identify caregivers struggling with mental health or substance abuse problems, or the impact of trauma? Are there home-visiting programs that identify babies and toddlers who may need infant mental health services? Do mental health agencies provide backup support or consultation?

10. What kind of routine maternal screening is available through healthcare providers' offices when a baby is born? Does this screening include questions on maternal depression and anxiety, substance abuse, and domestic violence?

11. What happens if screening results indicate that a caregiver is being challenged by one of these issues? Do healthcare providers have information about a referral network?

12. Is attention given to fathers, grandparents, and other caregivers who may also be struggling with these concerns?

13. Are there disparities in access depending upon income or insurance status? In other words, do healthcare providers see only those who can pay?

14. What other organizations have similar goals and might be willing to work on this problem? What types of partnerships would help achieve the objectives?

15. What are the possible treatments?

16. What kind of treatments and services are already available?

17. Do support groups for individuals and families exist?

18. What kind of family-focused treatment exists for families with young children? Is help through local health agencies available to children whose parents are challenged by mental health, substance abuse, or trauma? Through childcare? Through religious organizations? Through other settings?

Prevention

19. What are the possible preventive measures, solutions, or remedies?

20. Are other prevention programs being planned or implemented by other organizations?

APPENDIX E: CONDUCTING FOCUS GROUPS

Using information gathered from focus groups can be a valuable way to identify community needs and problems and to understand the perspectives of community members. The goal of a focus group is for participants to express their own points of view and behaviors. To better understand how focus groups differ from group discussions, see *Can You Call It a Focus Group? A Methodology Brief from Iowa State University* (http://www.extension.iastate.edu/publications/pm1969a.pdf). For a comprehensive series of guidebooks on conducting focus groups, see *The Focus Group Kit*, by David Morgan and Richard Krueger, Sage Publications, 1997.

RECRUITING PARTICIPANTS

There are a variety of ways to recruit participants. You can run an ad in a local publication, work with other community organizations, purchase lists of the phone numbers of individuals with certain characteristics, or identify professionals through a relevant association or mailing list service. You could also work through provider offices or local support groups, childcare centers, and community centers.

Think about whether you want to offer an incentive, such as money or food. Follow these tips when planning the logistics:

- Schedule sessions at times that are convenient for your potential participants (for example, at lunch or after work).
- Choose a safe and convenient site. Churches and libraries are a good choice and may provide space free of charge to nonprofits.
- Provide transportation (or reimburse participants for agreed-upon transportation costs).
- Arrange for child care, if necessary.
- Let participants know you'll provide snacks or refreshments.

DEVELOPING A MODERATOR'S GUIDE

The moderator's guide tells the moderator/interviewer what information you want from the participants and helps him or her keep the discussion on track and on time. Before this is done, you'll need to determine the following:

- What you want to learn from the focus group or interview;
- How you'll apply what you learn; and
- What tools (for example, descriptive information, message concepts, or other draft creative work) you'll need to provide for the sessions.

Write questions for the guide that relate to the purposes you have identified. Most questions should be open-ended, so that participants can provide more in-depth responses rather than just "yes" or "no." Also make sure the

questions aren't worded in a way that will prompt a particular response. For example, instead of asking, "What problems are you having finding someone you can trust to care for your child while you are at work?" you ask, "Are you having any problems finding someone you can trust to care for your child while you are at work ?" This will help ensure that participants offer honest responses, not the answers they think you want. The time and depth of exploration given to each issue should reflect the issue's importance to your purposes.

In the focus groups, don't include questions for group discussion if you need individual responses. Instead, you can have the moderator give each participant self-administered questionnaires to be completed before the session. Participants can also first be asked to individually rank items, such as potential actions, benefits, or message concepts, on paper and then discuss these during a session. In this way, you will get both individual and group reactions.

CONDUCTING THE FOCUS GROUPS

Focus groups typically begin with the moderator welcoming participants and briefing them on the process (for example, that there are no right or wrong answers, that it's important to speak one at a time and maintain confidentiality, that observers may be monitoring, that the session will be recorded). The moderator asks a few simple "icebreaker" questions to help participants get used to the process and to help reduce any anxiety. This also helps the moderator develop rapport with the participants.

Next, the session shifts to an in-depth investigation of participants' perspectives and issues. Following the moderator's guide, the moderator manages the session and ensures that all topics are covered without overtly directing the discussion. Participants are encouraged to express their views and even disagree with one another about the topics. The moderator doesn't simply accept what participants say but probes to learn about participants' thinking and attitudes. The moderator also seeks opinions from all participants so that all are heard, rather than a vocal few dominating the discussion.

Near the end of a focus group, the moderator will often give participants an activity or simply excuse him or herself for a moment to check with the observers (if you have assigned someone to this role) and obtain any additional questions. Notes can also be sent in to the moderator throughout the session if the observers want other questions asked or other changes made.

Source: Adapted from Mental Health America & Substance Abuse and Mental Health Services Administration (2009).

APPENDIX F: STRATEGIES FOR COALITION BUILDING

CREATE

Launch the coalition:

- Recruit a core coalition planning committee.
- Put relationships first.
- Identify an initial vision and common concerns as possible organizing issues.

Build an initial framework for working together:

- Create an appropriate decisionmaking and governing process.
- Determine the extent of decisionmaking by consensus.
- Share power from the very beginning.
- Honor different communication styles.
- Respect that not all partners will feel the same way about every issue.
- Take inventory and, if necessary, seek funds for the coalition's work—as a team.

CONNECT

Expand the circle:

- Agree on criteria for coalition candidates.
- Compile a list of potential coalition members.
- Check the interest and availability of coalition candidates.
- Plan and hold an organizing meeting of the coalition.

Build trust and mutual respect:

- Establish boundaries of acceptable behavior.
- Exchange gifts.
- Identify, compare, and celebrate assets.
- Share stories on advocacy and policy development successes and challenges.
- Put listening on the agenda.
- Provide support for group identification and cohesion.
- Acknowledge and respond appropriately to cultural and language differences.
- Solicit input and participation in various ways.
- Plan events and activities where people can experience success in working together.
- Remember the personal touch.

Organize around a vision, mission, and goals that promote change and continuity:

- Bring the right support to the table.
- Complete and document an environmental scan.
- Take a community inventory.
- Conduct focus groups to identify specific racial/ethnic group issues and possible cross-community issues.
- Identify areas of consensus and supply supporting documentation.
- Take time to craft a coalition vision, mission, and values that everyone endorses.
- Establish an action agenda with achievable goals and objectives.

Evaluate:

- Hold a group discussion about how evaluation could and should be used.
- Establish an evaluation committee.
- Recruit an evaluator to work with the coalition evaluation committee.
- Review the coalition action plan and determine evaluation benchmarks and criteria.
- Monitor progress on an ongoing basis.
- Report to the coalition and others.

COMMIT

Solidify the organizational structure:

- Decide on the life span and revalidate that decision periodically.
- Examine options available for organizing the coalition.
- Determine the most suitable organization for the coalition.
- Hire an appropriate level of staff to work on the coalition's behalf.
- Provide training, as needed, to strengthen the coalition's capacity and skills.
- Share leadership.
- Welcome and involve new recruits as coalition members of equal standing.
- Anticipate problems that could pull the coalition apart and develop plans to handle them.
- Plan to pass it on.

Plan for and establish financial stability:

- Take inventory of resources that coalition members can offer.
- Decide who should receive funds for the coalition.
- Identify acceptable and unacceptable donors.
- Develop short- and longer term budgets.
- Develop business, marketing, and fundraising plans.
- Seek funding from nontraditional sources.
- Provide coalition members with financial reports on a regular basis.

Communicate effectively:

- Develop an internal and external communications plan.
- Designate a communications monitor or task force.
- Identify and use members' specialized communications skills.
- Develop the coalition's logo and other "trademarks."
- Speak with one voice.
- Address members' special communication needs.

Celebrate:

- Build on success.
- Identify opportunities for victory along the way.
- Transform challenges into opportunities.
- Record the coalition's history and important events.
- Invite the community to share in the celebrations.
- Celebrate individuals, too!

Source: Adapted from Office of Minority Health (2004).

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