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EARLY INTERVENTION IN CHILDREN'S MENTAL HEALTH

FROM THE EDITORS. It is with great pleasure that we welcome you to the premiere *collaborative* issue of *Focal Point.* The joint effort between the Center For Effective Collaboration and Practice and the Research and Training Center on Family Support and Children's Mental Health exemplifies a larger partnership initiative put forward by the Center for Mental Health Services' (CMHS) Comprehensive Community Mental Health Services for Children and Their Families Program. The goal of an enhanced partnership is to promote improved services that lead to better outcomes for youth and their families. Along these lines we hope you find the fruits of our inter-agency collaboration positively reflected within the pages of this issue. Finally we extend our heartfelt thanks to you for the helpful feedback you provided in the reader's survey. Information from your responses was incorporated into this version of the bulletin.

This issue of *Focal Point* addresses the idea of "early intervention" in its most generic sense. The *interventions* described are efforts to provide services and supports to children and families in order to promote mental health and well-being, to reduce risk factors, and/or to address developing challenges or disabilities. What distinguishes these interventions as *early* interventions is that they are efforts to provide these supports and services either when the child is very young, as soon as there is an indication of risk, and/or at the first signs of challenging behavior or disability.

Several of the interventions described are *preventative*, in that their goal is to reach children and families at a point *before* a specific problem or disability develops. Some preventative interventions are universal, meaning that all children and/or families in a given population receive the intervention regardless of their personal risk or other challenges. In contrast, *selective interventions* are targeted towards children who are at significant risk of developing a behavioral or mental health challenge, while *indicated interventions* are targeted towards those who are showing specific signs that suggest that an emotional or behavioral challenge may develop in the future.

Often, these various types of preventative interventions are targeted at very young children, but it is also possible to target older children for prevention of mental health challenges that typically have their onset in adolescence. For children who do

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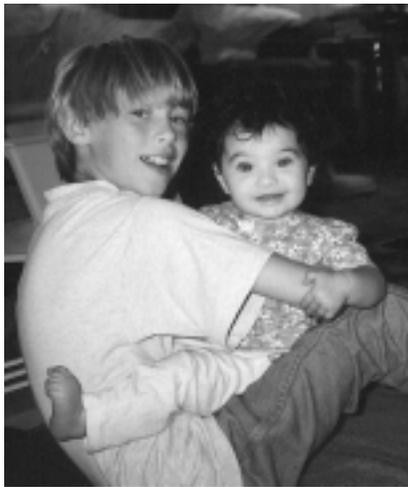**Underrepresented Researchers Mentoring Program**
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not receive preventative interventions, or for children who do not respond well to them, it is still desirable to provide appropriate treatment services at the earliest possible point in the development of the challenge.

It is important to point out that in some contexts the term "early intervention" may be used in a very specific way. In particular, under the 1997 Individuals with Disabilities Education Act (IDEA), "early intervention" refers only to services to children from birth to 2 years and their families, provided because of the young child's identified disability. This very focused definition of early intervention is one which would exclude, for example, preventative interventions of any sort. It is thus worth bearing in mind that the broad definition of "early intervention" which serves as the theme for this issue of *Focal Point* is not the only definition of the term in current use.

Poduska and Kendziora considered the question of how children in schools come to be referred for mental health services and how they can start receiving appropriate services as early as possible. Their perspective is that the current Admission-Review-Dismissal system is too adversarial and onerous to be effective for all of our children, and propose a systematic alternative to screening of whole classrooms and the integration of universal preventive interventions into the curriculum for all students.

Massetti and Whitehurst present an early reading intervention that has been rigorously evaluated. "Dialogic Reading" engages a young child in the process of telling stories about, appreciating, and enjoying picture books. The intervention improves emergent literacy skills, but more than that, may have untested effects on attitudes about learning, feelings of self-efficacy, and mental health.

Reid and Webster-Stratton describe an intervention developed for children at risk of conduct problems. The intervention is a strengths based approach, involving parents, teachers and children themselves in a positive program designed to teach and reward prosocial behavior

Dodge highlights the development of recent applied theories and intervention strategies in the field of Juvenile Justice and Delinquency prevention and illuminates the broader implication of such strategies in promoting mental health for youth. The multiplicity of models being implemented throughout the nation reflect the burgeoning awareness of the important role that families and communities play in building on the positive capacities of children and youth in preventing delinquency and promoting their general mental well being.

Benjamin points out that culturally diverse children from low-income backgrounds are at the greatest risk of developing mental health problems. She also notes that effective prevention strategies need to be tailored to address the particular risks faced by these children, and that services need to be designed and delivered in a manner which is culturally competent.

Knitzer and Cauthen examine the root of many of the problems that affect children—poverty. Furthermore they contend that specialists and policy makers within the field of early intervention must recognize the increasing imperative for advocacy in the area of poverty reduction, they also describe many of the various strategies that are already being implemented at the state and federal level.

Kaufmann and Wischmann identify the deficits in federal and state funding for the overall health care needs of the youngest in our society. Specifically, welfare reform and the subsequent financial hardships on parents and children dealing with mental health issues are explored. The authors propose a revised vision of Temporary Assistance to Needy Families and related welfare reform legislation that is more suitable to the ever-growing needs of families in our society.

As always we welcome feedback from you, our readers, and hope that the diversity of perspectives contained within will contribute beneficially to the ongoing discussion of this important topic.

KIMBERLY KENDZIORA, *Guest Editor*
ELIZABETH CAPLAN, *Editor*
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MENTAL HEALTH SCREENING AND SERVICES IN THE SCHOOLS: A PUBLIC HEALTH APPROACH

A large number of children in the U. S. have emotional and behavioral problems—most estimates place the numbers between 14 and 26%. These children are in need of services and supports, yet in some communities, fewer than 25% of children and youth with documented behavioral or emotional problems receive mental health services[1]. The gap between service need and service use only widens when considering children and youth with problems who do not meet criteria for psychological diagnoses or special education eligibility. Faced with this discontinuity between what children need and what they receive, the question of how children come to be engaged in mental health services becomes vital.

Schools have long been recognized as vital components of any effort to get mental health services to children "where they are." School-based mental health services have the capacity to reach children who are poorer, more ethnically diverse, and more deeply in need of services than those seen in clinics[2]. Schools are not only important points of service delivery, they are crucial points for early identification of service needs. The recent Surgeon General's report on Mental Health[3] noted that "schools are major settings for the potential recognition of mental disorders in children and adolescents" (p. xv). The mental health community is not looking at schools as merely other venues in which to set up services-as-usual. The education community has also expressed interest in going beyond their educational mandate and providing an array of services to children and their families. *School-based services, school-linked services,* and *full-service schools* are all phrases heard regularly from educators. Two comprehensive books on the subject are *Full-Service Schools*[4] and the Institute of Medicine's report, *Schools & Health*[5].

Currently, children who are strug-

gling in school because of emotional or behavioral challenges are referred either to outside mental health agencies or are internally referred for special education services. Schools represent the largest source of referral of children with serious emotional disturbance to community mental health networks. However, many children who are referred for outside services ultimately fail to receive them, for a variety of reasons.

Other children are referred for services within the school, through a special education eligibility process often called Admission-Review-Dismissal, or ARD. The ARD mechanism was developed out of the 1975 Education for All Handicapped Children Act (now reauthorized as the 1997 Individuals with Disabilities Education Act). The goal to provide a free and appropriate education for all students remains as important now as ever, but there have been some problems implementing the law.

One issue has been that the process of connecting children with special education services has often been legalistic and therefore adversarial[6]. Schools sometimes take extreme positions with respect to determinations of eligibility for their special education services. In some instances, school personnel act as gatekeepers, limiting access to their services, because the services available are typically restrictive, and eligibility crite-

ria may be interpreted strictly. Some schools may feel pulled by political or economic incentives to identify more children as disabled (to receive more federal and state funds per student). Other schools may use special education services as the panacea to any problem in the classroom, with special education becoming a "dumping ground" for students who need services that their teachers don't have the strategies or support to provide. Regardless of a particular school's attitude toward special education, the process of referral and eligibility can be difficult for families. In order to receive services, children with mental health issues typically must be "labeled" as seriously emotionally disturbed, emotionally handicapped, or as some other unappetizing phrase that acts as a trigger to set off the implementation of legally mandated services. Families often feel ambivalent about entering the process because they may want the services, but not the stigmatizing label.

The process of referring, labeling, and serving children within the schools can be both arduous and arbitrary. For example, teachers disproportionately refer the youngest children in a classroom for mental health services, although these children have the lowest rate of qualifying for services[7]. A large majority of referrals are initiated by teachers, who fill out a form bringing a student to the attention of what is variously called a "child study team" or a "multidisciplinary team." Teachers' decisions to begin the paperwork may be based as much on their judgments of how likely a child is to make it through the process as it is on their estimation of whether a child could benefit from the available interventions. Once a child comes to the attention of a school's administration, a meeting is held to discuss the issues and make a decision about whether or not to pursue formal evaluation. If evaluation is deemed necessary, a clock

starts ticking (often 65 days, but states can and do shorten this period), and evaluations (performed either by the school or at the school's expense) must be completed. If a family wants a type of evaluation, such as a neurological examination, that the school does not regard as necessary, then the family must pay for it.

Once the assessments are complete, another meeting is held at which the need for interventions, and their type and intensity, are determined. Children with identified disabilities receive Individualized Education Plans, and services begin. However, the ratio of children referred for special education services and children who ultimately receive them is roughly 2:1,[8] so roughly half of all children referred are not placed in school-based services.

Many professionals in schools—teachers, principals, and mental health workers—have long recognized the lack of efficiency and fairness of the basic special education referral system. Concerns about overidentification, misidentification, and bias have led to the development of prereferral interventions[9]. These programs typically employ a multidisciplinary team to identify classroom, instructional, or home-based changes that will better meet a student's needs. These interventions often lack the force of legal mandate, and do not automatically follow a student into other settings, such as a new school, a residential mental health facility, or the juvenile justice system.

Other solutions to the problem of meeting students' mental health needs have included the establishment of school-based mental health programs. Many such programs have been developed, either at the school or school district level or at the statewide level (as in California's *Healthy Start* initiative, which provides school-linked health and mental health services to economically disadvantaged children and families[10]). These programs are certainly helpful to children and families, but to date, they have not typically existed in the context of a public health framework that would create the most economical and efficient way to identify and meet the needs of all students.

Our thesis in this article is that the current system of mental health in schools could be improved by implementing a system of regular assessments, combined with multiple levels of preventive and treatment interventions. Our proposal does not represent any radical new thinking, but rather represents a simple extension of the public health model to the school environment. Our focus is on elementary schools—particularly the earliest grades. The model consists of the following five elements:

- Teachers should engage in regular screening of every child in their classroom.

- The curriculum for all students should include a component aimed at the prevention of emotional and behavioral problems among students.

- For students with noted risk factors or who are displaying early signs of problems, selective interventions should be available within the school.

- Some students receiving selective interventions may continue to have problems succeeding in school. For these children, more intensive, "indicated" interventions are necessary.

- Children not responding to indicated preventive interventions require treatment services, including but not limited to special education services. These services should be closely coordinated across any and all agencies and providers involved in the delivery of services.

In this article, we discuss a framework that includes the areas of assessment and intervention.

REGULAR SCREENING

For children, meeting the task demands of the classroom (such as sitting still, paying attention, and participating appropriately) is crucial for successful adaptation later in life. As such, those concerned with children's development would benefit from knowing what teachers think about how children are doing. Teachers' ratings are valuable because teachers are in such an important position with respect to young children. Teachers see children function both independently and in groups, and in both structured and unstructured situations. Teachers watch how children handle the transition from one activity to another. They see children in the morning and in the afternoon. Because teachers see so many children in all of these contexts, they have the breadth and depth of experience to make well-informed judgments about children's adaptation to the vitally important educational environment. Teachers are often the first people to notice that a child has problems requiring mental health, educational, and often, health services. Their engagement in the process of referral of children is absolutely critical.

Given that teachers possess such valuable information, the question becomes, "How, when, and to whom do they provide it?" The "how" question has been addressed fairly well by the research community. Several investigators have developed measures that allow teachers to quickly screen their students for their level of social adaptation to the classroom and to school. A measure familiar to us is called the *Teacher Observation of Classroom Adaptation*, or TOCA. The TOCA has been used for over a decade in the Baltimore City Public School System though the Johns Hopkins University, School of Hygiene and Public Health's Prevention Research Center. Its has been used by other researchers as well, in places such as Oregon, North Carolina, Washington, Pennsylvania, and Tennessee. In one project, the TOCA was employed specifically to identify children who had high levels of aggressive/disruptive behavior, in order that they could be provided with more intensive services.

One appealing feature of the TOCA is that it does not represent

additional paperwork for a teacher—it is an interview. In a friendly, personal format, teachers respond to a set of questions about each child in the classroom. For a class of 25–30 children, the interview takes approximately two hours. While the interview is being conducted, students can be guided by another assessment specialist in the completion of self-report measures of thoughts, feelings, and behaviors. Students can even be asked to provide information about each other, which provides tremendous insight as to the social organization of classrooms. Peer data allow administrators to identify students who may not be having academic or behavior problems, but who may be socially marginalized and who could benefit from skill-building (selective) interventions.

The TOCA was developed with extensive teacher input. The items were originally chosen by asking first grade teachers to identify specific task demands that they expected from their students. Thus, it reflects the teachers' standards of successful functioning, rather than clinical or mental health standards. This is an important point for a number of reasons. First, it is necessary to have teachers report on what they know in language they use. While many of the task demands of the classroom are tied to diagnostic symptoms (sitting still and paying attention, for example), teachers also know and care about qualities like motivation and readiness to learn. Although these are not "mental health" variables per se,

they may well mediate or moderate the course of an emotional or behavioral disorder.

When should teachers screen their students? The answer to this question may vary with the developmental level of the children involved. In the earliest grades, when children are maturing at faster rates, three times a year may be appropriate. Later on, say fourth grade until middle school, twice a year may be sufficient. Generally, teachers need some time to get to know their students, and to begin to see how they are adjusting to the variety of activities within the classroom and the school. Mid-October is usually a good time for an initial assessment. As mentioned, midyear screenings may be valuable when children are rapidly developing academic and social skills. The last screening of the year should not be so close to the closing of school that nothing can be done with the results of the assessment—early to mid-May would be reasonable in many cases.

To whom should teachers report on their studentsí adaptational status? We believe that there needs to be close collaboration among families, regular education and special education teachers, school mental health personnel, school administrators, and other community stakeholders to determine the uses of the data, and how it will be connected to other school records such as academic achievement data. Trust and support are important issues. Teachers need to know that the information they provide will be used constructively, not punitively. Teachers also need to know that if they identify an emotional, behavioral, health, or educational problem, something will be done about it—supports for the student, the teacher, or both. The point of conducting systematic assessments is not to fill filing cabinets, but to serve children. The goal is to provide the earliest and least restrictive level of intervention possible in order to prevent as much as possible the occurrence of serious problems. To do this, we must move from an emphasis on referral, which necessitates taking action once a

problem manifests itself, to an emphasis on continuous dialogue about how students are doing in the classroom.

The TOCA is a good example of a useful "first-stage" measure. It can be used to keep track of children's functioning, to ensure that as soon as there are signs that a student is struggling and may need help, "second stage" assessments can occur. These measures can determine service needs for those children for whom preventive measures are not enough. These measures and methods are much more developed in most schools as they have long been the domain of school psychologists. On this front, what is needed is to ensure that the second-stage measures used, and the interventions they employ, fit within a comprehensive framework.

PREVENTIVE INTERVENTIONS

It is not enough to identify and provide services to the most seriously ill children, or even the children most at risk of developing a disorder. As the range of children who would benefit from mental health and educational interventions is broad, the gamut of interventions provided to children must be broad as well. Preventive interventions are a critical piece of an integrated system of services from prevention to treatment, because many of the risk factors associated with poor outcomes, such as early behavior problems and poor achievement, have been shown to be changeable. The aim of preventive interventions is to reduce the number of children who will have a disorder or, at the least, reduce the severity and/or duration of illness.

There is no shortage of effective prevention programs. In the last thirty years, prevention scientists have learned a great deal about what works, and for whom, in school-based prevention. Several agencies have published or have otherwise made available bibliographies of prevention programs that meet specified criteria and have received the label "proven efficacious," including the Center for Substance Abuse Prevention and the Office of Juvenile Justice and Delin-

quency Prevention. Funders have recognized both the importance of prevention when providing a broad range of services and of using empirically proven programs. For example, in the *Safe Schools/Healthy Students Initiative*, funded jointly by the Departments of Education, Health and Human Services, and Justice, communities competing for Federal grants had to show that they would implement "proven" prevention programs. The challenge in establishing preventive interventions is not a lack of available programs, the challenge is a lack of integration in the service system which keeps children from being identified with precision, and in a timely manner, so that problems do not develop later on. A dedicated school-based mental health professional is required to ensure the quality and proper coordination of services.

■ **Universal Preventive Interventions.** There are three levels of preventive interventions, each focused at specific population. In a comprehensive program of services, intervention and assessment mesh seamlessly, so that as soon as a need for more intensive services is identified, those services can be made available quickly.

The first level of preventive interventions, universal interventions, are delivered to everyone in a population, such as a classroom, or a school. These interventions are not restricted to specific children. Often, universal interventions aim at strengthening some aspect of the environment. These interventions are designed to be cost effective and can usually be delivered without additional professional assistance. Some examples of school-based universal preventive interventions are training teachers in behavior management skills, teaching children social skills or academic skills, and providing workshops for parents to strengthen the relationship between the home and the school.

■ **Selective Interventions.** The next level of preventive interventions are called selective preventive interven-

tions. These interventions are aimed at children whose risk of developing a disorder is higher than average due to the presence of one or more risk factors. The particular factors that could put an individual at risk include gender, age, or environment. For example, a selective intervention may exist for children of divorced or single parents, for children from poor neighborhoods, or for children who have been abused or neglected. Some selective interventions reach out to children from violent neighborhoods, or from communities with large illegal economies (guns, drugs, and prostitution).

■ **Indicated Interventions.** The third level of preventive interventions, referred to as indicated preventive interventions, are provided for those children who are at individual risk for developing a disorder as evidenced by the manifestation of low, but detectable levels of symptoms or signs known to foreshadow a disorder. Indicated prevention programs include those for children who have been identified by parents or teachers as having behavioral problems. Other examples are initiatives targeting youth with juvenile justice contacts, gang members, or pregnant students.

■ **Treatment.** Within a public health framework, the term "treatment" is reserved for those interventions designed to reduce or eliminate an episode among children meeting full cri-

teria for a psychiatric diagnosis or special education classification. Alcohol and drug treatment programs would be included here, as would most Wraparound initiatives for children identified as seriously emotionally disturbed. Although treatment requires a diagnosis, in practice, the line between prevention and treatment is often blurred. Children who would meet criteria for a disorder may receive programming under the rubric of indicated prevention to avoid labeling the child. Conversely, it may also occur that children receive a diagnosis, even without meeting strict criteria, when treatment services are billable and preventive services are not. As integrated systems and funding streams are developed, these types of mislabeling should be diminished.

INTEGRATION OF INTERVENTION AND ASSESSMENT

Although each level of intervention should reduce the proportion of children needing more intensive services, the non-responders to each level of intervention need to be identified quickly in order to provide them with the most appropriate care. An early identification system for school children must be integrated within a system of interventions from prevention to treatment. This integration cannot occur only on paper, but must evolve through the careful establishment of mutual self-interests among families, educators, mental health

Estimates of numbers of students involved in each level of intervention[11]

Treatment: **0–5%**
Indicated interventions: **2–20%**
Selective interventions: **5–30%**
Universal interventions: **50–85%**
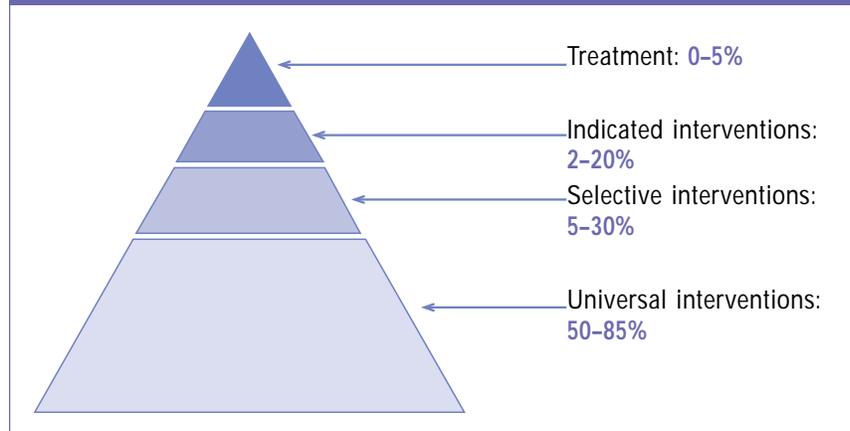
professionals, and other community stakeholders.

Without doubt, the fields of education and mental health are at a closer juncture than they have been for many years. If collaborations can be sustained and institutionalized, the benefit for children, families, and communities will be great. The level of concern among policy makers is high, and funding is available. To serve children in the best way, we must move forward, but in a way that integrates assessment and intervention in a conceptually coherent, precise manner. We hope that this thumbnail description of a public health model might provide a framework for communities to begin their discussions.

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OPHELIA SPOKE AND I LISTENED

My mom rushes off the plane to meet me at school after one of her whirlwind trips and the first thing she says to me is "You have to read this book." My mom is always trying to get me to read this or that book, listen to this song or watch this movie, and then exasperated by the look on my face she says, "I'll never make you read another book again." But I'm glad she did. *Ophelia Speaks* was written by seventeen-year old, Sara Shandler, who felt that girls' voices needed to be heard. This is an amazing book, heart wrenching, shocking and honest.

The stories of my female peers will make everyone pay attention to the private horror many adolescent girls live through that you don't necessarily notice when passing through the halls or competing for the last slice of pizza in the lunch line. I am left wondering what are the private stories of pain that boys aren't sharing with one another, or if they are, more of us need to hear from them.

My mom explains to me after reading this book, that I could write a book review for *Focal Point.* The issue she explains is on early identification and intervention. After struggling to explain the concept to me she draws this analogy, "You know when you get the slightest hint of a cold and I make you take echinacea and zinc so that it doesn't become full blown, well that's kind of like early identification and intervention."

My mom and I have very different philosophies about the common cold. I think it might be better to let a cold run its course and give the adolescent mind and body a much-needed rest. Yet, there are some pains that you should not leave alone or let go and hope they will go away naturally. Many of the pains that children experience won't be outgrown. Now that I'm thinking about "identification" after reading this book I think of how we kids can identify with each other much more easily. That is the gift we provide to each other and maybe the adult world could benefit from our specialty.

I'm obviously not any kind of expert or professional but I do know that people like Sara Shandler who ask young people to tell their stories of pain and joy are doing a big deal in helping kids. The sooner kids can identify for themselves and for each other what it is that hurts them, then hopefully the sooner they will receive the help they need to live happier lives.

—Joseph Brandon Caplan
He will finish West Sylvan Middle School this spring

EARLY INTERVENTION TO PROMOTE PRESCHOOLERS' LANGUAGE SKILLS: DIALOGIC READING

Over a third of children in the United States enter school unprepared to learn. They lack the vocabulary, sentence structure, and other basic skills that are required to do well in school. Children who start behind generally stay behind—they drop out, they turn off. Their futures are at risk. Why do so many children struggle with the skills that are critical to school readiness? Children's experience with books plays an important role.

Picture book reading provides children with many of the skills that are necessary for school readiness: vocabulary, sound structure, the meaning of print, the structure of stories and language, sustained attention, the pleasure of learning, and on and on. Children who are read to three times per week or more do much better in later development than children who are read to less than three times per week. It is important to begin reading to children at an early age. By nine months of age, infants can appreciate books that are interesting to touch or that make sounds. Preschoolers need food, shelter, love; they also need the nourishment of books.

Picture book reading also provides an ideal context for learning language. Adults often approach shared reading with an intent to teach language to their young children. A large set of studies suggests that the particular way that parents read to their children may have an impact on children's language ability. Thus, it is not surprising that studies have shown that the frequency with which children are exposed to picture books is related to language skills. We must be careful,

however, not to assume that just because exposure to books and language skills go together, that the one directly or uniquely causes the other. For instance, preschool experience with books may be a "side effect" of socioeconomic differences among children, and it may be the economic differences that carry the true weight in predicting academic readiness and success. Alternatively, the relations between early experience with books and language development may be due to the fact that children who are more interested in books during the preschool period may initiate more shared book reading with adults: "Mommy, will you read with me?" The same underlying abilities and inclinations that generate more interest in books may also foster rapid language development independently from the early book reading experience. Thus, experimental studies are necessary to establish the direction of effects in the relationship between shared book reading and language development.

The Stony Brook Reading and Language Project has developed a method of reading to preschoolers called *dialogic reading* which is aimed at increasing stimulation of

children's language skills through interactive picture-book reading. When most adults share a book with a preschooler, they read and the child listens. In dialogic reading, the adult helps the child become the teller of the story. The name of this intervention comes from the word "dialogue," and establishing a dialogue between adults and children about fun, engaging stories is what this intervention is all about.

WHAT IS DIALOGIC READING?

The dialogic reading program is based on three general principles:

1. Evocative techniques are used to encourage the child to take an active role during story time. For example, asking the child a "what" question is preferable to straight text reading or asking the child to point. This principle is based on evidence that active learning is more effective than passive learning, and that language, like other skills, benefits from practice.

2. Adult feedback is encouraged in the form of expansions, modeling, corrections, and praise. There is an abundance of data demonstrating the importance of providing children examples of slightly more advanced language than their own.

3. Progressive change in adult standards for the child are encouraged so that the parent or teacher is constantly encouraging the child to do just a bit more than he or she normally would. For example, a child should know what an object is called before being asked about what the object does. Dialogic reading is based on the premise that language development may be accelerated if the

boundaries of a child's comfort zone are pushed further than they might be spontaneously.

The specific reading techniques of dialogic reading require that adults gradually reverse the typical pattern of storybook reading to permit the child to become the teller of the story and the adult the active listener—prompting, expanding, and rewarding the child's efforts to talk. No one can learn to play the piano just by listening to someone else play. Likewise, no one can learn to read just by listening to someone else read. Children learn most from books when they are actively involved.

Using Dialogic Reading with Two- and Three-Year-Olds

The dialogic reading program for two- and three-year-olds is presented in two segments. Training may occur one-on-one, in a group, or even by videotape. In any mode of training, the following topics are covered.

Dialogic Reading: Part One (Seven Elements)

1. Ask "what" questions. Practicing language helps children to learn, so asking "what" questions that evoke speech from a child encourages a greater use of language. For example, pointing to a fire truck and asking, "What is this?" Such questions are much more effective than questions, that do not require any speech from the child. Similarly, yes/no questions are not very effective at increasing the child's language skills. Asking, "What is this?" while pointing to a fire truck encourages more speech from a child than asking, "Is this a fire truck?" or asking the child to point to the fire truck.

2. Follow answers with questions. Once the child knows the name of a picture object, adults are encouraged to ask further questions about the object. For example asking questions about aspects of the object itself, such as its shape, its color, or its parts. Asking what the object is being used for or who is using it also elicits greater use of language on the part of the child. Any question that asks the child to talk about the object, in other words, is helpful. If a child correctly labels a wagon, for example, the adult might point to its wheel and say, "Right, what is this part of the wagon called?"

3. Repeat what the child says. Reinforcing the child's correct responses by repetition provides encouragement and lets the child know when he or she is correct. So if the child answered "frog," the adult might say, "That's right, it is a frog."

4. Help the child as needed. A child's inability to answer a question provides a good opportunity for teaching. Adults are asked to provide the child a model of a good answer, and to see if the child will repeat what they said. For instance, the adult might say, "Those are roller skates. Can you say roller skates?" Children eventually get into the habit of repeating without being asked.

5. Praise and encourage. There are many ways to provide feedback and praise when the child says something about the book, such as "Good talking," "That's right," or "Nice job."

6. Follow the child's interests. Children learn very quickly when they are learning about the things that interest them. At this age it is not important to read all of the words on a page or talk about every picture. It is important to talk about the things that the child likes. When the child points at a picture, or begins to talk about part of a page, adults are to use this interest as a chance to encourage the child to talk.

7. Have fun. The most important thing to remember about this program is to make reading fun. We have found that children generally enjoy an active approach to story time, particularly when adults take a game-like, turn-taking approach. If the child seems to be getting tired, adults are encouraged to read a few pages without questions, or take a break from reading. It is important to try to keep these two phases in proportion by simply reading to the child part of the time. One way is for the parent or teacher to read a page, and then for the child to read the next.

Dialogic Reading: Part Two (Three Elements)

1. Ask open-ended questions. In part one the child was asked specific questions about objects and their attributes. In part two, adults are to ask less structured questions—questions that ask the child to pick something on the page and tell about it. Examples of these open-ended questions are "What do you see on this page?" or "Tell me what's going on here." These questions are more difficult than specific questions. At first the child may be able to answer very little. It is important at this stage to encourage any attempts, and provide models of good answers. When the child doesn't know anything else to say about a picture, adults are to provide a multiword description and try to get the child to repeat it: "The duck is swimming. Now you say, 'the duck is swimming'." After a few days' practice, the child should begin to offer multiword phrases spontaneously in response to the request, "Tell me about this." After the child gets used to answering these types of questions, adults may be able to ask two or three such questions on a page. When the child says something about a page, he or she is to be praised, and then asked what else he or she can say. When the child runs out of things to say, adults can add one more piece of information and try to get the child to repeat it.

2. Expand what the child says. When the child says something about the book, this language should be encouraged and used as an opportunity to model slightly more advanced language. This is done by repeating what the child says and adding a bit more information or one or two more words. For example, if the child says, "Duck swim," the adult might say, "Right, the duck is swimming." If the child says, "Wagon," the adult might say "Yes, a red wagon." Adults can expand on what the child has said by adding parts of speech or by supplying new information. Later, the child

Transcript of Dialogic Reading:
A parent reading *Just Me and My Little Sister* (by Mercer Mayer) to a child

P: *Just me and my little sister. (Shows cover, begins to turn pages)* Who do you see in this picture?
C: Mama.
P: That's right. What is the mom holding?
C: Broom.
P: The mom is holding a broom. What does she use it for?
C: The floor gets clean.
P: That's right! Mom is using the broom to clean the floor. *(Reading)*: *My little sister wanted to go to the park. Mom was too busy, so I said, "I'll take her." So we went to the park, just me and my little sister.* What do you see on this page?
C: Critter.
P: Critter is on the page. She is pulling a wagon. What color is it?
C: Red.
P: It's a red wagon. What parts does it have?
C: Wheels. Sister.
P: The wagon has wheels, and yes—Sister is getting a ride in the wagon. What else is in the wagon?
C: Ball.
P: Sister is holding a basketball— that's right. *My little sister wanted to play basketball, but the hoop was too high.* Look at all the animals! What kind of animal is this *(points)*?
C: Mousy.
P: That's right. That is a mouse. Now I'll find one. See, this is an alligator. What game are all these animals playing?
C: Basketball.
P: They are playing basketball. Good. *She wanted to play jump rope, so I showed her how.* What is Critter jumping over?
C: Jumper
P: He is jumping over a jump rope. Just like *(child's older sister)* does. What happened to Critter and the jump rope over here?
C: *(Laughs)* Fell down and tangled.
P: That's right! He got tangled up by the jump rope!
C: Funny Critter.
P: Critter does look funny. Look, even Sister is laughing. *Then she wanted to play hide-and-seek, but she got lost.* Where is Sister?
C: Hiding in bush.
P: Sister is hiding in the bush—why is she hiding?
C: It's a game!
P: That's right—they are playing hide-and-seek! *My little sister climbed to the top of the jungle gym. I had to help her get down.* This jungle gym has two colors. What colors do you see?
C: Orange and yellow.

P: That's right—the jungle gym is orange and yellow. *She wanted to go on the big slide, so I caught her at the bottom.* Look—it's your favorite—you love the slide! What color is this slide?
C: Orange. Not yellow.
P: That's right. It's orange, not yellow, like the one in the backyard. *I gave her a ride on the merry-go-round, but it went too fast.* Who is laughing in this picture?
C: Sister. Critter looks scared.
P: That's right. Sister is laughing, and Critter looks scared. Very good! *So I let her go on the swing until she was tired.* What is Sister doing?
C: Swinging.
P: Critter is pushing Sister on the swing. Is she tired, or is she having fun?
C: Critter looks tired. Sister having fun.
P: That's right! Critter looks tired, but Sister is having fun. *Then she was thirsty, so I helped her drink from the fountain.* Why is Critter holding her up?
C: Sister too short.
P: Sister is too short to reach the water fountain. That's right. Where did the water go?
C: *(Laughs)* On Critter's head!
P: Critter's head is wet, that's right. *My little sister went to the sandbox. She wanted to play mudpies.* What did the mouse and the bunny build?
C: Castle.
P: They built a sandcastle. What is Sister doing with the water?
C: Gonna break the sandcastle.
P: It's going to get the sandcastle wet, and it will get ruined. Is that a nice thing to do?
C: No—Sister bad.
P: That was a bad thing to do...*but it was time to go home.* Who is crying?
C: Bunny.
P: Bunny is crying, and?
C: Mouse.
P: Bunny and mouse are crying. Why are they crying?
C: Sister broke the castle.
P: Sister ruined their sandcastle. That made them sad. *My little sister had such a good time at the park that Mom says I can take her again tomorrow.* They're not at the park anymore. Where are Sister and Critter now?
C: Home. Mom holding Sister.
P: That's right, they are home now, and Mom is holding Sister. What do you think Sister is telling Mom?
C: About the park.
P: That's right. I bet she's telling Mom about how much fun they had at the park! That's the end of the story. Let's go back and this time, you can read the story to me!
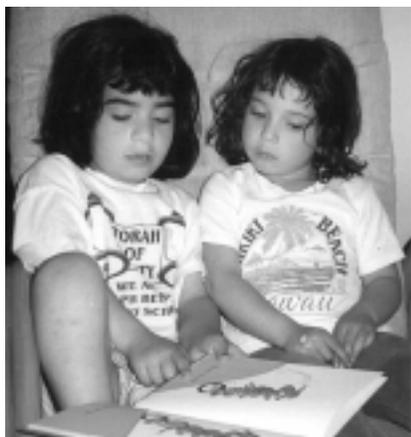
can be asked questions about the information provided, such as "What color is the wagon?" When the child's utterances are expanded, it is important to make sure only a little information is added, so that the child will be able to imitate. If the expansions are too long, the child is unlikely to be able to repeat what is said. If the child is encouraged to repeat expansions, he or she is more likely to use longer phrases spontaneously.

3. Have fun. It is important to use one's judgment in adjusting this program to make it fun for the child. The child can't be expected to do all of the talking about a book. The adult should talk about some of the pages, or take turns describing a picture. Many children find turn-taking to be like a game.

A transcript of a session of dialogic picture book reading is presented on page 11.

THE EVIDENCE BASE
FOR DIALOGIC READING

The effects of the dialogic reading program were originally evaluated with a group of suburban mothers and their two-year-olds[1]. Half of the families were randomly assigned to an experimental group and received training in the reading assignments described above. Mothers in this group received two half-hour training sessions two weeks apart. Each training session consisted of three components: (a) *didactic instruction* in which the techniques were described to the mother by the trainer; (b) *mod-*

eling of the techniques in which the trainer gave a demonstration of the techniques and role-played a reading session with a trained research assistant; and (c) *direct feedback* in which the trainer pretended to be a child and had the mother practice the techniques, providing feedback about her performance. The other half of the families were assigned to a control group. These mothers read to their children as often as mothers in the dialogic reading group, but read in their typical manner. Mothers in both groups tape-recorded reading sessions across the four-week study.

Analyses of the audiotapes revealed that mothers who were trained in dialogic reading made use of the techniques, whereas control mothers primarily read the books' text. Over the four-week intervention period, the dialogic reading program produced significant increases in how long children would talk during reading. Effects of the dialogic reading intervention were also found on measures of expressive vocabulary.

EARLY INTERVENTION USING DIALOGIC READING WITH CHILDREN IN POVERTY
High Risks among Poor Families

There are widely documented social-economic differences in the language use of preschool children. Children who live in underprivileged conditions consistently perform more poorly than more priviledged peers on standardized tests of verbal ability and on other diverse measures of verbal production. Furthermore, social-class differences in language production are present from the early stages of language development: Differences in the size of children's vocabularies are detectable as early as 18 months of age.

Children raised in poverty are also at very high risk for later illiteracy and school failure. The *National Assessment of Educational Progress*, an ongoing project of the Department of Education, has consistently documented substantial differences in the reading and writing ability of children

as a function of the economic level of their parents[2]. As research indicates, school achievement varies with socio-economic status. These differences exist at the very beginning of school, and children's school performance is relatively stable from kindergarten to high school. Without intervention, very often children from low-income families start school behind and stay behind.

One of the contributing factors to the early language deficits in many low-income children may be a lack of effective, early shared reading experiences. In fact, children who live in poverty often receive very little exposure to literacy materials. By one estimate, a typical middle-class child enters first grade with approximately 1,000 to 1,700 hours of one-on-one picture book reading, while a corresponding child from a low-income family averages just 25 such hours[3]. Because reading with children is so important, and because children whose families suffer economic challenges are particularly at risk of poor reading and language outcomes, dialogic reading may be especially helpful for children who live in poverty.

The first replication study of the effects of dialogic reading was conducted in a setting that was not only economically distinct from the original suburban, middle-to-upper socio-economic status families, but also culturally distinct. In this way, any results obtained could be said to be robust across several important contextual elements. The extension project was conducted with two-year-old children attending a public day care in Tepic, Mexico[4]. The families in this study had an average income of only $192 per month. The intervention consisted of dialogic reading as described above, using five books from the series, *Teo Descubre el Mundo (Teo Discovers the World)*. The results of this project showed that compared to children who received arts and crafts instruction, children who participated in dialogic reading had improved scores on a variety of language measures—including expressive and receptive vocabulary.

Closer to home (in Suffolk County, New York), we began the work of extending dialogic reading to children in Head Start and their families. As in the Mexican study, the "home base" for dialogic reading was not the home, but was the preschool. This new work was of broader scope, including 167 four year-olds across four Head Start centers in the first wave of evaluation. Half of the group received the regular Head Start curriculum, and half were involved in a year-long, dialogic-reading based emergent literacy curriculum. Children receiving the intervention engaged in regular small-group dialogic reading with their teachers. These same children took home the book that was being used in the classroom each week for use at home. Given the more advanced developmental stage of the children in this project (four year-olds vs. two year-olds), an additional, whole-class intervention component included a half-year program focused on teaching letter sounds. At the end of the school year, results showed large and educationally significant effects of the intervention on writing and concepts of print. Effects on language depended on how involved the parents were, with children of very involved parents showing large improvements in language skills.

The next school year (1993-1994), we conducted a replication study with 153 children in four different Head Start centers, and obtained similarly impressive results at the end of the school year. Effects of dialogic reading have been found in at least five other studies as well, including projects in Nashville, Tennessee and Worcester, Massachusetts.

To date, children in the New York studies have been followed through second grade. Effects of the dialogic reading-based emergent literacy curriculum were observed through the end of kindergarten, but were not evident on word reading or word attack assessments at the end of first or second grades. Several explanations for the lack of continued observed effects are plausible. One is that the public school curriculum brought the children who did not receive our intervention "up to speed," so that they were no longer different from the children who had participated in dialogic reading. Another possible explanation is that dialogic reading is about building a habit of shared reading, engaging children in the world of picture books, and enjoying the experience of stories—outcomes that are not captured in word attack tests, but may nonetheless be of some benefit to children. Future studies might include assessments of these more nuanced effects, such as attitudes toward learning and sense of mastery in storytelling.

CONCLUSION

Dialogic reading is innovative in that young children learn to become storytellers. Done well, dialogic reading not only improves emergent literacy, but it is fun, and among some children may foster a love of reading. By itself, dialogic reading with preschoolers will not produce a nation of readers. But it can be a valuable component in a family's, school's, or nation's strategy to start moving in the right direction.

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PREVENTING CONDUCT PROBLEMS AND PROMOTING SOCIAL COMPETENCE IN HEAD START CHILDREN: *THE INCREDIBLE YEARS* PARENT, TEACHER, AND CHILD SERIES

BACKGROUND

Aggression and conduct problems are disturbingly common in the pre-school-age.[1] In fact, studies report that as many as 20% of young children meet diagnostic criteria for Oppositional Defiant Disorder and these rates are highest among low-income families.[2] When left untreated, these "early-onset" conduct problems are stable over time and are the most important behavioral risk factor for predicting the development of delinquency, violence, and substance abuse in adolescence.[3] These data highlight the need for effective, low-cost, and easily delivered early intervention/prevention programs for young, at-risk children. The current article will describe one such prevention/early intervention program in detail: *The Incredible Years* training series, developed by Carolyn Webster-Stratton. Originally designed and evaluated for treatment of children with diagnosed conduct problems,[4] the series has recently been evaluated in two studies as a prevention program for use with high-risk Head Start populations.[5]

THE INCREDIBLE YEARS TRAINING SERIES

The Incredible Years training series is a comprehensive set of training curricula designed to address the three major areas related to the development of conduct problems: the child, the family, and the school. The series consists of group-based training programs for parents, teachers, and children. The programs may be used separately or as an integrated, comprehensive prevention model. Each program consists of over 200 videotaped vignettes of common situations faced by parents, teachers, or children. In the prevention versions of the programs, 35-40% of the parents, teachers, and children shown represent minority groups. Vignettes show effective and ineffective ways of handling these situations, and provide the framework for group discussions on how to handle common problems. In addition to the vignettes, each program contains detailed treatment manuals with session-by-session checklists, group-leader scripts, homework materials, books, and activities. Webster-Stratton has also outlined a process for training and certification of group leaders. These manuals, materials, and certification guidelines ensure that the program can be replicated effectively by other researchers as well as by clinicians working in applied settings. Below, we outline the format and content of the parent, teacher, and child programs and describe their use in Head Start settings.

THE PARENT PROGRAM

The BASIC parenting program can be offered as a preventive intervention in 12-16 weekly, 2-hour sessions. The program begins by building on the strengths of positive parent-child interactions through teaching parents to engage in child-directed play ses-

sions with their children. Subsequent units focus on encouragement, praise, tangible reinforcement, ignoring, limit setting, natural and logical consequences, and Time Out. Material on anger management, working with schools and teachers, academic success, problem solving with children, and encouraging children's peer relationships is also covered. In addition to watching the videotaped vignettes, parents discuss and role-play common situations in the group and are given weekly homework consisting of reading and behavioral assignments to try with their children. The groups are lead in a collaborative format whereby the leaders present material and provide structure to the discussion, while parents set their own goals and extract parenting "principles" from the material presented.[6] Group members are encouraged to build supportive networks through the assignment of "buddies" who call each other between groups. We have found that to encourage parent participation, it is crucial to address practical barriers to attendance (such as providing child care, transportation, and food for each meeting, and offering home-based make-up visits for missed sessions). Group leaders also encourage participation by calling parents to "check-in" between sessions, acknowledging individual and group successes, and soliciting and responding to parenting feedback after each session.

THE TEACHER PROGRAM

Similar in format to the parent program, the teacher program is taught in 4-6 day-long sessions spaced throughout the fall and winter of school year (the program could also be offered in shorter, more frequent sessions). The teacher program consists of units on building positive

relationships with students, building parent-teacher collaboration, encouraging parent participation, the importance of teacher praise and positive attention, proactive strategies to prevent problems, using tangible reinforcement, decreasing inappropriate behavior with limit-setting and Time Out, and increasing children's prosocial and problem-solving skills. As with the parent program, the teacher program is offered as a collaborative venture between the group leader and the teachers. Role-plays and discussion are used to illustrate new concepts. Teachers are seen as the experts and are encouraged to use each other as resources for solving difficult problems in the classroom. With the group leader's guidance, teachers help each other to make changes at the classroom-level as well as implementing individual behavior plans for challenging students. Classroom assignments to use in circle time or activities to practice during the day help to generalize new ideas to the classroom. In order to ensure the highest level of teacher engagement, we have found it is important to obtain administrative support for the program and to include teachers in planning when and how the training will occur. Teacher engagement during the training can be promoted by providing food and door prizes, offering course credit for participation, training teachers and their classroom aides, paying for substitute teachers, using daily evaluations to modify subsequent sessions, and providing teachers with certificates of completion.

THE CHILD PROGRAM: DINOSAUR SCHOOL

The Dinosaur Program for children was originally designed as a treatment program to be delivered in small groups of children with conduct problems. Recently the program has been revised for use as a classroom-based prevention/early intervention program. The classroom-based curriculum can be used with children in preschool through grade three. The program contains units on school

rules, doing your best in school, feelings, problem solving, anger management, making friends, and teamwork. The classroom-based program is designed to be delivered 2-3 times per week in short (15 minute) large group lessons, followed by small group (6-8 children) activities to practice the new skills. Teachers are provided with suggestions about how to structure their classrooms to reinforce the skills through out the day. Thus, children have multiple opportunities to see, practice, and use the new skills they are learning. As with the parent and teacher programs, the program content is illustrated through videotaped vignettes that children watch and discuss. In addition, the Dinosaur Program uses child-size puppets to discuss and role-play content with the children. Suggestions for activities, materials for games, colorful cue cards illustrating key concepts, homework activity books, and teacher scripts are provided for each lesson.

HEAD START AS A CONTEXT FOR PREVENTION/ EARLY INTERVENTION

Head Start is an ideal setting for the implementation of prevention programs designed for the preschool age group. Research shows that Head Start children experience an increased number of risk factors associated with the development of conduct problems. Because of the many challenges they face, they are at risk for developing serious behavioral problems. Second, Head Start has great potential as an effective and efficient service delivery method for gaining access to large numbers of families and children who are at risk. Each center has a staff of teachers, assistants, and family service providers whose goal is to work together to provide comprehensive services for children and families. Thus, unlike most other preschool programs, Head Start has existing staff who, with training, are uniquely positioned to deliver classroom and parenting interventions. However, although parent education is an important mission of Head Start, few Head Start programs have placed

an emphasis on the use of empirically validated parenting programs. Additionally, although many Head Start teachers and family service workers are very well trained, there is considerable variability in the level of training of Head Start staff. Some teachers and family service workers have had little formal training in child and parent education or in the implementation of social skills training. Thus, the use of empirically validated parent and teacher programs, along with extensive training and support for staff in how to implement these programs, can enhance the quality of the Head Start program.

THE EFFECTS OF PARENT AND TEACHER TRAINING IN HEAD START

The parent program has now been evaluated in two separate randomized, controlled prevention studies in Head Start.[8] In the first study,[9] Head Start Centers were randomly assigned to receive parent training or the regular Head Start Program. Mothers who received the parenting program were significantly less harsh and critical and significantly more positive and competent than mothers not receiving the extra parent training. Teachers reported that mothers receiving the intervention were more involved in their children's education than were mothers who did not receive the intervention. Children of mothers in the parent-training program exhibited significantly fewer negative behaviors and conduct problems, and were reported by their teachers to be more socially competent than the children of parents who did not receive training. Most of these improvements continued to be evident at one-year follow-up. The parenting materials were translated into Spanish and Vietnamese and the groups were offered in both languages in addition to English. Consumer satisfaction for the program was very high for all language groups. In the second study,[10] Head Start Centers were assigned to an intervention condition that included parent *and* teacher training, or the regular Head Start Program. The par-

ent findings from the first study were replicated at the end of the Head Start year. Families in this second study were also offered 4 additional "booster" sessions during their child's kindergarten year designed to help children make a smooth transition from Head Start to regular public school. Data from one- and two-year follow-up periods are currently being collected for this study.

Results of the teacher training offered in the second study[11] are very positive. Following training, intervention teachers were observed to use less harsh and more appropriate discipline and to use fewer critical statements and more praise in the classroom compared to teachers who did not receive training. Intervention teachers also reported more involvement with parents. Observers' impressions of classroom atmosphere were more positive for intervention than

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control classrooms, and children in intervention classrooms were observed to be less aggressive, more engaged, and to show more school readiness skills than control children.

The child program has been evaluated in a randomized controlled study with 4-8 year old children with conduct problems. In this context, the program improved child behavior at home and improved children's conflict management skills with peers.[12] We are currently in the first year of a Head Start Partnership grant designed to evaluate the prevention version of the Dinosaur Program in Head Start classrooms. We expect that when used with entire classrooms, the program's effectiveness will be enhanced. When the program is delivered to all children, more socially skilled children can model skills for those who are having more difficulty. Furthermore, if all children receive the program, there is no stigma associated with "pull-out" groups delivered only to those children who are having difficulty. The classroom teachers will be available to reinforce new skills throughout the day, which will increase the dosage of intervention. The entire culture of the classroom can be focused on helping each child to succeed, making generalization to real life situations (such as free play, play ground, circle time) more likely. Furthermore, since it can be difficult to offer intense family-based interventions to multiply stressed families, it is important to understand the effects of a program that is delivered entirely through the school.

IMPLICATIONS

The need for early intervention/ prevention for high-risk children is urgent. Left alone, these children are at risk for developing academic and behavioral problems that eventually escalate to adolescent and adult delinquency, violence, and substance abuse at great cost to the individual, the family, and to society. This article highlights one training series that has been proven to enhance protective factors (e.g., positive parenting and teaching, and child prosocial skills)

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and decrease risk factors (e.g., harsh parenting and teaching and aggressive/noncompliant child behavior) that can determine child outcome. Programs such as *The Incredible Years* that strengthen home and school environments, are community-based, cost-effective, manualized, and empirically validated should be routinely offered as a part of high-risk children's early school experience. This type of early intervention is well worth the investment.

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EARLY PREVENTION AND INTERVENTION
EQUALS DELINQUENCY PREVENTION

Created in 1974, the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention (OJJDP) focused its delinquency prevention efforts primarily on middle-and high school age youth for more than 15 years (U.S.Dept. of OJJDP, 1976). OJJDP did not consider early prevention or intervention to be unimportant, it simply considered early prevention and intervention efforts to fall within the purview of other Federal agencies. In the early 1990's, as OJJDP became increasingly aware of research establishing the early origins or pathways to delinquency, OJJDP began to expand its prevention efforts to include evidence-based programs that intervened early in the lives of children, including prenatal programs. What follows is an examination primarily of some of the delinquency literature relating to the causes of delinquency, the pathways youth take on their trajectory toward delinquency and what has been learned about delinquency prevention. Although, there is also some discussion of related issues with regard to mental health problems among youth, the discussion emphasizes that the noted research findings point to the need for early prevention and intervention.

Howell summarizes a number of studies that show that there are risk factors in several domains of a child's life that may lead to delinquency and substance abuse (Howell 1995, p. 18). These research efforts have enhanced the understanding of the precursors of delinquency. Children are not born delinquent. Most children and youth do not engage in serious delinquency because they have various protective factors in their lives that enable them avoid serious delinquency and substance abuse. Unfortunately, a significant proportion of youth in the United States do engage in serious and violent delinquency. This is largely because some youth are most likely more vulnerable and the risk factors

in the various domains of their lives are so extensive that these youth engage in a number of negative and risky behaviors, including delinquency or substance abuse, despite the presence of some protective factors.

In developing its approaches to delinquency prevention, OJJDP has been aided by research on risk and protective factors conducted by Dr.'s David Hawkins and Richard Catalano (Hawkins,Catalano, & Miller 1992b). Although their research focused on risk factors for substance abuse, subsequent research by them and the others noted in the previous paragraph has demonstrated that these risks factors are virtually identical with the risk factors for delinquency. In their research, funded initially by OJJDP and later by the Center for Substance Abuse Prevention (CSAP), Substance Abuse and Mental Health Administration (SAMHSA), Hawkins and Catalano took a public health approach to substance abuse and delinquency. Just as there were well known risk factors for heart disease, they reasoned that there must be risk factors for delinquency. Their work led them to identify *risk factors* in several domains of a child's life: individual, family, school and community. Examples of such risk factors for delinquency include the following (Hawkins, Catalano & Miller 1992a):

■ **Individual/Peer**—a difficult temperament, early initiation of behavior problems, and friends who

engage in problem behavior.
■ **Family**—excessive punishment, inconsistent or ineffective child management practices, family conflict, and parental involvement in drug abuse.
■ **School**—academic failure starting in elementary school, early and persistent antisocial behavior.
■ **Community**—community disintegration, community norms that support drug abuse or crime, and poverty.

Hawkins and Catalano also identified several *protective factors* that enable many youth, despite a myriad of risk factors, to avoid delinquency and substance abuse. These include the following (Hawkins, Catalano and Miller 1992a):

■ **Individual**—a resilient personality.
■ **Family**—effective family management skills and supervision.,
■ **Community**—family and friends that help the youth become bonded to the community, involvement in faith based activities i.e., attendance at a church, synagogue or mosque.

In response to their findings, Hawkins and Catalano have argued for a Social Development Strategy to delinquency prevention called "Communities that Care" (Hawkins, Catalano & Miller 1992a). They argue that the key to delinquency prevention is understanding the risk factors a child or youth faces, developing effective programming to overcome them, and building on the protective factors that are present in the child's life. Hawkins and Catalano's work has become an important part of OJJDP's "Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders"(Howell, 1995). The "Comprehensive Strategy" is an overarching strategy, based on current delinquency theory, that demonstrates the importance of creating a continuum of services and sanctions to prevent delinquency and effectively

intervene with delinquent offenders. Training on the Comprehensive Strategy is taking place in eight States and several communities.

Other significant research has shown that youth follow distinctive pathways in their delinquency careers. Funded by OJJDP, a longitudinal study, the *Causes and Correlates of Violent Delinquency* conducted by Loeber, Huizinga and Thornberry was initiated in 1987. It encompasses three separate but coordinated studies: the Denver Youth Survey, the Pittsburgh Youth Study, and the Rochester Youth Development Study (Lorber, et al., 1999). The published papers from these studies provide a wealth of information on serious and violent delinquency and the pathways youth take in becoming delinquent. The researchers found that children and youth generally take one of three pathways to delinquency: overt authority conflict, overt aggression, or covert pathways (Loeber, et al., 1999). These pathways are characterized by different responses (Loeber, et al., 1999). In the overt aggression pathway, the child tends to act out aggressively, engaging in fighting and progressing to crimes against persons. The overt authority conflict pathway is characterized by stubborn behavior, defiance and disobedience, eventual truancy and running away, and serious property crime. In the covert pathway, a child is withdrawn and secretive, progressing through thefts to burglary and more serious crimes (Loeber, et al., 1999).

Patterson, Forgatch, Yoerger and Stoolmiller (1998), examined how aggressive behavior in children changes over time. "The findings show that the higher the initial level of disruption in parental discipline and transition, the further the penetration into the trajectory. This movement into the trajectory was further enhanced if the individual was currently heavily involved with members of the deviant peer group" (Patterson, et. al., 1998, p.544). Patterson and his colleagues argue that these findings have significant

implications for prevention studies. They emphasize the role of parental child rearing practices and the importance of the family's contribution to the social milieu in which the child lives. The "findings also underscore the importance of reducing the amount of time the preadolescents and adolescents spend in routine activities that are not supervised by adults" (Patterson, et al., 1998, p. 544).

These studies also suggest that certain early indicators of a troubled childhood and high stressed family and community environments can be significant contributors to later delinquency. Thus, the studies support the need for early intervention with services and supports that address risk and protective factors present in a child's life. Further evidence of the value of early intervention can be found in many other studies in a variety of disciplines.

In addition to delinquency and substance abuse, mental health problems, find their origins in early childhood. The Surgeon General's Report *Mental Health: A Report of the Surgeon General (U.S. Department of Health and Human Services, 1999)* provides a thorough discussion of the risk factors for the development of serious mental health problems among children and youth. "There is now good evidence that both biological factors and adverse psychosocial experiences during childhood influence—but do not necessarily "cause"—the mental disorders of childhood.... Although children are influenced by their psychosocial environment, most are inherently resil-

ient and can deal with some degree of adversity. However, some children, possibly those with an inherent biological vulnerability (e.g. genes that convey susceptibility to an illness), are more likely to be harmed by an adverse environment, and there are some environmental adversities, especially those that are long-standing or repeated, that seem likely to induce a mental disorder in all but the hardiest of children" (U.S. Dept. of HHS, 1999, p.129). The environmental risks for mental disorders are in many cases the same as the risks for delinquency and substance abuse. The report identifies and discusses in some detail risk factors for developing a mental disorder or experiencing problems in social-emotional development. The authors drawing from various studies indicate that these risk factors "include prenatal damage from exposure to alcohol, illegal drugs, and tobacco; low birth weight; difficult temperament or an inherited predispositions to a mental disorder; external risk factors such as poverty, depravation, abuse and neglect; unsatisfactory relationships; parental mental health disorder; or exposure to traumatic events" (U.S. Dept. of HHS, 1999, p.129).

The Surgeon General's Report highlights the critical importance of addressing risk factors for children and youth at the earliest possible point in their development. "Childhood is an important time to prevent mental disorders and to promote healthy development, because many adult mental disorders have related antecedents in problems in childhood"(U.S. Dept. of HHS,1999, p.132). The report further notes "Policymakers and service providers in health, education, social services, and juvenile justice have become invested in intervening early in children's lives: they have come to appreciate that mental health is inexorably linked with general health, child care, and success in the classroom and inversely related to involvement in the juvenile justice system" (U.S. Dept. of HHS, 1999, p.133).

Early intervention strategies are critical to the prevention of many of the negative outcomes that youth in our society experience: drug abuse, teen age pregnancy, school failure and school drop-out, and delinquency. Several early prevention and intervention programs have been shown to work effectively for children with multiple problems and their families. Over the past few years OJJDP has devoted an increasing proportion of its resources to fund early prevention and intervention.

In 1996, OJJDP began funding, *Safe Futures: Partnership to Reduce Youth Violence and Delinquency* (Kracke, 1996). This five-year program is designed to support the efforts of local jurisdictions to develop and implement a system of care for at risk and delinquent youth. Nine funding sources, from the Juvenile Justice and Delinquency Prevention Act of 1974, as amended, are being used to underwrite this initiative. Awards were made to Boston, Massachusetts; Contra Costa County, California; Fort Belknap College, Montana (American Indian Reservation); Imperial County, California (rural site); St. Louis, Missouri; and Seattle, Washington. Sites were encouraged to use current assessments or conduct additional assessments to determine the risk factors prevalent in their communities, available community resources and services to address those risk factors and the gaps between needs and resources. The program design calls for the sites to use the Federal funds provided to fill these service gaps. These funds can be used for early intervention services and supports through aftercare programming. A number of the sites have developed early intervention efforts, such as a mentoring program with elementary school children and after-school programs for this same population. An evaluation is being conducted by the Urban Institute that focuses on, 1) process outcomes, 2) systems change outcomes and 3) analysis component effectiveness.

Safe Kids, Safe Streets: Community Approaches to Reducing Abuse and Neglect and Prevention Delinquency Program is jointly funded by several Office of Justice Program agencies. OJJDP is administering this 5 1/2 year program in five communities: Chittenden County, Vermont; Huntsville, Alabama; Sault Ste. Marie Tribe of Chippewa Indians, Sault Ste. Marie, Michigan, Kansas City, Missouri; and Toledo, Ohio. The communities are developing coordinated responses to child abuse and neglect that include prevention, intervention, and treatment services. The evaluation is being conducted by Westat, Inc.

Observing the potential of the Yale/New Haven Child Oriented Community Policing program for preventing delinquency by providing effective services to children exposed to violence, OJJDP funded the Yale Child Study Center and the New Haven Police to provide training and technical assistance to other jurisdictions. This model incorporates training for law enforcement personnel on the mental health needs of children exposed to violence and uses joint teams of law enforcement and mental health specialists to respond to situations involving children's exposure to violence. Children receive follow up mental health services from community agencies (Marens and Berkman, 1997).

The most recent early prevention and intervention initiative, *Safe Start*, for which OJJDP announced funding on February 29, 2000, is designed to prevent and reduce the impact of family and community violence on young children, primarily from birth to 6 years of age. The Safe Start demonstration project originated as an expansion of the successful Child Development Community Oriented Policing Program (CD-CP) that OJJDP has supported. The program expands the CD-CP concept by including a comprehensive service delivery system for young children exposed to violence or at risk of exposure to violence, and their families and care givers. Safe Start communities will enhance existing partnerships among service providers in the fields of law enforcement, mental health, child welfare, domestic violence, early childhood education and development, courts, family support and strengthening, substance abuse prevention and treatment, crises intervention, health and legal services to create a more comprehensive service system. Nine sites will be funded under this program. In addition, an American Indian Tribal site will be funded later in fiscal year 2000.

Del Elliot and his colleagues at the Center for the Study of Prevention of Violence, at the University of Colorado, have identified a number of evidence-based delinquency prevention and intervention programs. Under the resulting evidence-based "Blueprints" program, OJJDP is supporting several early intervention efforts. One such program is the *Nurse Home Visitation Program* developed by David Olds, which provides intensive in-home services to pregnant teenage mothers. The program helps participating mothers develop parenting skills and other life skills and provides referral to other services. A 15-year longitudinal study demonstrated that there were fewer incidents of child abuse among program participants than nonparticipants. Children had fewer behavioral and parental coping problems. Participating mothers were more involved with their children and juvenile delinquency among the participating youth was greatly reduced

as compared to the control group. (Olds, D. 1998). Recently, the Robert Wood Johnson Foundation has funded a Center on Nurse Home Visitation which will be directed by Dr. David Olds.

Another early intervention program identified under the "Blueprints" program is *Promoting Alternative Thinking Strategies (PATH)*. (Greenberg, Kusche & Mihalic 1998) A school-based intervention designed to promote emotional competence, including the expression, understanding, and regulation of emotions; the program is implemented by teachers after receiving three days of training. The program is applied to all children in grades kindergarten through fifth grade. The curriculum includes a feelings unit (with a self-control and initial problem-solving skills program within the unit) and an interpersonal cognitive problem solving unit. The program also helps the children use what they have learned in their every day lives.

> *There have been four clinical trials of PATHS. Two have involved [students with special needs] and two involved [students in typical education settings]. Across these trials, PATHS has been shown to improve protective factors (social cognition, social and emotional competency) and reduce behavioral risk (aggression and depression) across a wide variety of elementary school-aged children. Effects have also been found on some cognitive skills. In addition, these findings have shown cross-rater validity, as they have been reflected in teacher ratings, self-reports, child testing/interviewing, and independent ratings by classroom observers (Elliot, Greenberg & Kusche, 1998).*

In addition, OJJDP funded the Court Appointed Special Advocates (CASA) program efforts for several years. National CASA provides training and technical assistance and pass-through funding for local CASA chapters. CASA volunteers provide advo-

cacy and referral services to children who are in the abuse and neglect system whose cases are before the juvenile or family court. CASA volunteers also advocate in court for the best interests of the child.

In the mental health area, OJJDP has had a long standing partnership with the Center for Mental Health Services (CMHS), SAMHSA and currently jointly funds two major efforts initiated by CMHS. For three years, OJJDP has transferred funds to CMHS to support the technical assistance and training for the *Comprehensive Community Mental Health Service for Children and Families Program* sites. OJJDP, also, transferred funds to CMHS to support the *Circles of Care* program. The program provides resources to American Indian reservations and Alaskan Native villages to assist them in planning for and developing a system of care for at risk and delinquent youth.

There is one other initiative that OJJDP has just launched that OJJDP hopes will have far reaching benefits for juvenile offenders who need mental health services. On February 9, 2000, OJJDP published an announcement for the *Mental Health and Juvenile Justice: Building a Model for Effective Service Delivery* in the Federal Register. This five-year research and program development effort will examine the prevalence of mental health and substance abuse problems among juvenile offenders, and the development of an evidence-based or promising program model that can be implemented and tested in several jurisdictions.

Delinquency, substance abuse, and mental health problems among the youth of the United States are taking a terrible toll. This toll is reflected in the unacceptable levels of chronic, serious and violent juvenile offending, the victimization of the innocent, the growing numbers of lives disrupted by substance abuse and mental health disorders, and the increasingly burdensome costs imposed on society, including those entailed in detaining and incarcerating juvenile offenders. Moreover, our communities are permeated with fear, despite the fact that juvenile crime, in particular violent juvenile crime, has markedly decreased over the past five years. Because of this fear, we often fail to recognize that, in large measure, these problems are preventable. Much more is known at this time about the causes of delinquency and substance abuse and the kinds of programs that are highly effective in preventing these problems. Despite this evidence, this nation devotes far too little of its resources to early prevention and intervention. Rather, we often wait until destructive behaviors erupt and then apply costly retributive and incapacitative responses to address them. The politics of being "tough on crime" often prevents us from taking a more informed approach to the early prevention of the causes of delinquency and crime. It seems that to the lists of "war on poverty" and "war on drugs," we have added a "war on delinquency" in which children and youth are seen as the enemy. This is born out in the increased incarceration of juveniles despite the decline in serious and violent juvenile crime and the substantial increase in transfer to criminal adult courts of juveniles at younger ages for an increasing array of crimes.

Many in juvenile justice have come to the view that waging "war on delinquency;" should not be the primary strategy to address juvenile crime and related problems. Instead this country should, building on what we currently know, devote its resources and creativity to a campaign

for healthy families, children, and youth. If this is done, the result will be healthier families, children and youth, more productive youth and families, and safer communities at far less cost to society.

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KATHERINE SEELMAN, NIDRR DIRECTOR RECEIVES AAP AWARD

Katherine D. Seelman, Ph.D., Director of the National Institute on Disability and Rehabilitation Research (NIDRR), Office of Special Education and Rehabilitative Services in the U.S. Department of Education, has been selected by the Association of Academic Physiatrists (AAP) as the 1999 recipient of the AAP Outstanding Public Service Award. This AAP award is given to non-AAP members whose outstanding public service has significantly contributed to the field of Physical Medicine and Rehabilitation.

The AAP has cited Dr. Seelman for her "long term efforts in promoting coordination and cooperation among Federal agencies supporting rehabilitation research" that have "resulted in more attention to the need for and financing of research for the field of PM&R."

Dr. Seelman has served as the director of NIDRR for the last six years. NIDRR, with a budget of approximately $110 million, is a comprehensive Federal research agency with programs in medical rehabilitation, engineering and the social and behavioral sciences.

NIDRR also administers a technology program that supports the integration of assistive adaptive technologies in the homes and workplaces of persons with disabilities in the fifty states and the U.S. territories and an international program and a dissemination and utilization program, including Americans with Disabilities Act technical assistance projects.

Dr. Seelman is chair of the Interagency Committee on Disability Research, and she has been co-chair of major U.S. and international delegations in disability research and science. She also has been the recipient of a distinguished Switzer fellowship and a National Science Foundation Assistantship. She is a member of the Hunter College Hall of Fame and was recently named a 1999 fellow of the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

CULTURAL COMPETENCE IN EARLY IDENTIFICATION

It is widely acknowledged that culturally diverse children from low-income backgrounds are at the greatest risk of developing mental health problems. Although it is difficult to predict with any degree of certainty whether a particular child who is at risk of developing an emotional disorder will in fact develop one; we do know that early identification is a powerful tool in preventing emotional problems (Davis, 1998). By recognizing and understanding (a) the advantages of employing effective prevention strategies, (b) the significance of child development issues, and (c) the important role which culture plays in the lives of all children, the service delivery system is in a unique position to combat the stressors which impact negatively on the emotional/behavioral development of all children, especially culturally diverse children from low income backgrounds.

Stressors that some of these children face and that have been shown to affect mental health include: parental psychiatric or physical illness; low socioeconomic status, poor medical and dental care, significant personal loss; living in a single parent family; living in poor disorganized neighborhoods that offer limited opportunities for employment, recreation and socialization; abuse and neglect; family and community violence; and social and environmental factors such as racism, discrimination, and social isolation.

The Surgeon General's Report on Mental Health makes it clear that the U.S. Mental Health System is not well equipped to meet the needs of racial and ethnic minority populations and these populations are generally considered to be underserved by that system (U.S. DHHS Surgeon General Report, 1999). Moreover, according to Gibbs and Huang (1998), social scientists have paid little attention to the unique developmental issues of children from these populations, educators have demonstrated little understanding of their special needs, and

mental health professionals have expressed little awareness of their special problems. This suggests that early identification of these children have yet to rise to a high priority level in our system of care. Indeed as early as 1982, Knitzner found that children of color with mental health problems were not identified (Knitzner, 1982, cited in Hernandez & Isaacs, 1998).

Despite findings such as Knitzer's, little has changed since 1982 in the way services are provided to most children of color. We know for example that preventive interventions are effective in reducing the impact of risk factors for mental disorders and improving social and emotional development through such programs such as parent-education and home visits. However, cultural differences exacerbate the general problems of access to these programs (U.S. DHHS Surgeon General Report, 1999).

Increasing the cultural competence of services is an essential step in developing effective early intervention programs for children of color and their families. Providing services in a culturally competent manner means that practitioners, agencies, and systems are able to respond appropriately to the needs of culturally diverse children and their families,

beginning with an effective program of early identification. Cultural competence implies action and the ability to learn and become more knowledgeable about the needs, beliefs, values, traditions, and behaviors of culturally diverse children, their families and communities. It is defined as a set of congruent behaviors, attitudes, policies and structures that come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in the context of cultural differences (Cross et al, 1989).

If early identification efforts are to become more effective in serving children of color and their families, it is crucial that an infrastructure for cultural competence implementation is in place. Isaacs points to a number of core components that are seen as essential in building a solid infrastructure for cultural competence. They include: (a) commitment from top leadership to support early identification programs involving at risk culturally diverse children, (b) needs assessment and data collection (both quantitative and qualitative) to assist in knowledge development about culturally diverse children, families and communities in order to develop effective early identification strategies, (c) identification and involvement of key persons of color in a sustained, influential and critical capacity in the early identification process, (d) development of a cultural competence strategic plan with clear and measurable goals and anticipated outcomes related to early identification, (e) development of mission statements, definitions, policies and procedures that explicitly state the organization's cultural competence values and principles related to early identification, (f) targeted early identification strategies that are culturally appropriate and centered around improved outcomes for children and families, (g) development of an internal capacity to oversee and monitor the early identification process, (h) evaluation and

research activities that provide ongoing feedback about progress, leads to needed modifications, and guides next steps, and (i) commitment of human and financial resources to the early identification process (Isaacs, 1998).

Once an infrastructure for cultural competence has been established for identifying at risk children, service providers must deal with numerous developmental issues within a broader ecological context (Wright, 1998, cited in Hernandez & Isaacs, 1998). This includes not only understanding the intrinsic personality characteristics of the child, but as stated previously, consideration must also be given to the impact of such social and environmental factors as racism, social isolation and economic inequity on the mental health of the child (Isaacs & Benjamin, 1991).

Furthermore, how a child is doing in life generally reflects expectations based on pooled knowledge about child development that is culturally transmitted from one generation to another. Studies of resilience, competence, and psychopathology all point to the importance of establishing a good start early in development (Masten & Coatsworth, 1998). Childhood is an important time to promote healthy development, to prevent mental disorders, and to intervene before problems are established and become more refractory (U.S. DHHS, Surgeon General Report, 1999). It therefore follows that one should provide "at risk groups" with specific targeted interventions including such services as home visiting and parent education within a cultural context.

Many professionals in the field believe that the strengths of an individual's culture of origin can be incorporated into mental health or other interventions with children and that these strengths should be used to reinforce the cultural identity and integrity of the family (Benjamin, 1998). They believe that early identification using strategies based on culture is likely to have a powerful impact on preventing disorders. Family centered prevention and giving parents the tools they need to be advocates for programs and resources required to support their children is seen as an effective strategy. Once identified, it is useful to involve the natural support network that exist within communities and carefully match intervention strategies to the cultures of the families involved.

In conclusion, much is being learned about mental health intervention in response to early manifestation of emotional/behavioral needs among children. Communities that are active in such programs as Head Start and other pre-school programs are identifying children whose behaviors may not reflect severe disorders or functioning impairments, but may respond positively to targeted interventions (Davis, 1998). If these programs utilize principles of cultural competence, then the potential for providing effective early identification, early intervention and prevention services to culturally diverse children, families and communities is enhanced.

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PARTNERSHIP NEWS

from the Comprehensive Community Mental Health Services for Children and Their Families Program

NOTICE:

TRAINING INSTITUTES June 9-13, 2000. New Orleans, Louisiana. Developing Local Systems of Care for Children and Adolescents with Emotional Disturbances and their Families: Improving Policy and Practice. In-depth, practical information on how to develop, organize, and operate coordinated, community-based, family-focused, culturally competent systems of care for children and their families and how to provide high quality, effective clinical interventions and supports within them. For more information, contact the National Technical Assistance Center for Children's Mental Health at Georgetown University, 3307 M Street, NW, Suite 401, Washington, DC 20007, (202) 687-5000.

Do you want to know more about the National Children's Mental Health System of Care effort? A recent journal article provides a wonderful overview, explaining many of the past developments and current progress on this important topic. See Pumariega, A.J. & Vance, H.R (1999). School-based mental health services: The foundation of systems of care for children's mental health. *Psychology in the Schools*, 365), 371-378

NEWS FROM THE CENTER FOR EFFECTIVE COLLABORATION AND PRACTICE

■ **Addressing Student Problem Behavior—Part III: Creating Positive Behavioral Intervention Plans & Supports.** This is the third document in our series on Functional Behavioral Assessment and Behavioral Intervention Plans. It takes a closer look at using the results of the functional behavioral assessment to create, implement, and evaluate the effectiveness of appropriate and effective behavior intervention plans and supports. Sample resources and plans are provided. The first two documents in the series are also available by contacting the Center.

■ **Safeguarding Our Youth: An Action Guide for Safe Schools.** This companion volume to the much acclaimed *Early Warning, Timely Response: A Guide to Safe Schools* offers strategies and supports to teachers, schools, districts and others who wish to implement the research-based practices recommended in the first volume to make their schools and communities safer for all students. This document is due for release and distribution in May 2000.

■ **Educational Strategies for Children with Emotional and Behavioral Problems.** This handbook has been produced in co-operation with the American Federation of Teachers and the National Education Association and is a tool targeted to the needs of teachers and paraprofessionals that work with students with emotional and behavioral problems. Its clear language and practical strategies can be used as a ready reference in any setting

and can help provide educators with an overview of the Individuals with Disabilities Education Act law and regulations and research-based practices for working with these students. *Available now!*

■ **Promising Practices for Safe and Effective Schools.** This video from the national invitational conference Safe and Effective Schools for All Students: What Works, showcases three programs from around the country that have had success in creating safer and more effective schools and communities. The video includes footage from each program and interviews with program directors and staff, parents and community members, and is available for $17 from the national Juvenile Justice Clearinghouse, 1-800-638-8736 or www.juvenilenet.org.

■ **Valuing and Addressing Diversity: A Guide to Implementing Culturally Competent Special Education Services.** This document will provide educators and families with an overview of issues related to providing culturally competent educational services for students with emotional and behavioral needs. The guide will include research-based promising practices and targeted strategies to address the identified issues. Mandates and practices outlined in the 1997 Amendments to the Individuals with Disabilities Education Act will serve as the framework for conceptualizing topics related to: consultation and problem-solving practices, screening, and assessment. The document will also link to other relevant materials and resources. This document is due for release in late 2000.

All products are available from the Center for Effective Collaboration and Practice are available, except where indicated. The Center can be contacted at 1000 Thomas Jefferson Street, NW, Suite 400, Washington, DC 20007. (202) 955-5400 or toll-free 1-888-457-1551. E-mail: center@air.org or www.air.org/cecp

CARING FOR EVERY CHILD'S MENTAL HEALTH

POVERTY REDUCTION STRATEGIES
AS EARLY INTERVENTION

FRAMING THE CHALLENGE

Early intervention for children means many different things. In the most general sense, it means intervening with children whose familial or other experiences place them at risk of developing emotional or behavioral problems or developmental delays. School-based mental health teams working with children in elementary school are often referred to as early intervention teams. Early intervention is also used to refer to specific services targeted to young children with identified problems that place them at risk of poor developmental outcomes. Thus the Part C program of the Individuals with Disabilities Educational Act (IDEA) is referred to as the Early Intervention Program for Infants and Toddlers. In general, the intervention involves some kind of help targeted to particular children and families, or those who work with them, although sometimes efforts are targeted to a broader group, such as a class or a Head Start program. While recognizing the importance of these meanings of early intervention, this article takes the position that traditional early intervention needs to be supplemented with broader strategies aimed directly at a root cause of problems in many children—poverty.

WHY POVERTY REDUCTION STRATEGIES AS EARLY INTERVENTION?

Many low-income parents bring enormous resilience and strength to the task of raising children. But there is also a compelling body of research indicating that children in low-income families are disproportionately at risk of poor developmental outcomes. Indeed, everyone knows the litany. They are likely to do worse in school, to be in poorer health, and to need more special services than their more affluent counterparts. Being poor is, in and of itself, a serious and pervasive risk factor. In addition, being poor places special burdens and stresses on parents that may be reflected in harsh or inconsistent parenting. Further, low-income parents, and especially mothers, are disproportionately affected by depression, substance abuse, and domestic violence—factors which also threaten healthy parent-child relationships, thus putting children at risk.[1]

Poverty affects large numbers of children. In 1998, some 13 million children between birth and 18 were in families with incomes at or below the federal poverty line. (That year, the poverty line for a family of three was $13,880.) About 40 percent of these children were living in extreme poverty, that is, in families with incomes at or below *half* the poverty level. Another 13 million children were in families living "near poverty," that is with incomes up to 185 percent of the poverty line. Research suggests that poverty is especially harmful to the development of *young* children.[2] Some five million children under six are poor, with about half of them living in extreme poverty. Another four million young children live in families with incomes up to 185 percent of the poverty line.

WHAT ARE POVERTY REDUCTION STRATEGIES?

Poverty reduction strategies aimed directly at families generally fall into one of two categories. The first category includes *strategies to help families increase their income and assets or reduce their expenses.* One of the most effective policies has been the federal Earned Income Tax Credit, which provides tax savings and additional income to families with low earnings. Some states have refundable earned income credits as well, and some provide tax credits for child care and housing costs. Incentives to help families accumulate savings, through mechanisms such as Individual Development Accounts, are also promising. Benefits such as food stamps, child care subsidies, and Medicaid are beneficial not only because they provide access to needed services and supports, they also reduce family expenses.

A second category involves *strategies to increase the earning capacity of adults.* For today's adults, this means expanding access to higher education and vocational training as well as providing specialized assistance to the most disadvantaged adults, such as enhancing literacy or developing English proficiency among non-native English speakers. For tomorrow's adults, it means enhancing young children's development to set the stage for later learning and future employment. Policies range from high-quality child care and early education services to measures to help parents foster the healthy development of their children, such as providing parents with basic information about how children learn and develop as well as other types of parenting support.

For poverty reduction strategies to work, efforts are needed to ensure that families know about and have access to benefits and services for which they are eligible. Programs such as the Earned Income Tax Credit and the Children's Health Insurance Program aren't helpful if families don't know they qualify or how to obtain benefits. Thus, outreach strategies that make information and enrollment available through places of employment and

through child care, health care, and other service providers are critical.

WHAT A DIFFERENCE A STATE CAN MAKE

Child poverty levels vary enormously from state to state, ranging from roughly 7 to 30 percent. There are many reasons for this; their variations reflect the overall health of a state's economy to levels of education among the population to the kinds of employment available at the low end of the wage scale. As a result of the booming economy, most states have experienced declines in their child poverty rates in recent years, although a handful of states have experienced increases. States also vary in their policy responses to poverty. More and more, states are going beyond federal efforts to raise the incomes of low-income families. Eleven states have set the minimum wage above the federal level and eight states have enacted refundable earned income credits.

Another approach at the state level has been to increase eligibility levels for health care and child care benefits. Providing benefits for families with incomes up to two and a half times the federal poverty level, for example, helps families that lack health care coverage through their employers or for whom child care costs are prohibitive because of low wages. Such efforts are designed to support employment and to prevent families from becoming destitute to begin with.

States vary tremendously in how they've shaped their welfare policies

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in the wake of federal reforms and dramatically reduced caseloads. Some states have used the cost savings to invest in those families that remain on the welfare rolls, for example, by providing more education and training opportunities for those who lack job skills or increased services for parents suffering from depression or drug abuse. Other states are using welfare savings to help low-income families who are not receiving cash assistance, making the state earned income credit more generous or providing one-time offers of financial assistance to families facing a crisis. Meanwhile a substantial sum of federal welfare dollars remain unspent as states grapple with the unfamiliar problem of having surplus funds!

What's important about this current variation in state (as well as local) policy is that it represents a work in progress: policies that support low-income families are in a state of flux—which means there are new opportunities to address poverty and poverty reduction in a comprehensive way.

WHAT ARE THE IMPLICATIONS FOR EARLY INTERVENTION ADVOCATES?

Now is an important time for early intervention advocates to pay attention to child poverty reduction strategies. The broader advocacy community and policymakers are beginning to frame more comprehensive agendas to address child poverty and the needs of low-income families. Both national data and recent state polls suggest that Americans believe child poverty ought to be addressed. NCCP, is, in fact, working with a few states to develop strategies to join the efforts of advocates, policymakers, business leaders, and the broader community to ensure that children have what they need to thrive. At the national level, most of the major candidates for President, addressed the issue in some way.

Adding a poverty reduction perspective to the tools of early intervention advocates means forging new coalitions with those whose primary

agenda is economic security for families at the local and state levels. It means examining state policies with respect to poverty reduction and supporting national agendas to sustain poverty reduction effort. It also means working hard to see that every child in each community has access to ongoing health care and to child care that provides a nurturing and stimulating environment whether or not the child has special needs. Early intervention providers can help by telling families how to access these basic family supports. Although these tasks have not traditionally been defined as part of the role of early intervention or other service providers, they are key to implementing a comprehensive poverty reduction agenda.

Advocates for early intervention—that is, family members, policymakers, providers, and others—have an important perspective to bring to the table about why a poverty reduction agenda counts. Early intervention advocates are in an important position to bear witness to the strains on low-income families of having to deal with children with special needs. Federal programs to support early intervention, in particular Part C for infants and toddlers with developmental delays (or in some states, those at risk of developing such delays) and the preschool special education programs, are income neutral. They are not means-tested programs. This, of course, is as it should be. But as a result, there has been little specific attention paid to how these programs work for low-income families and whether such families encounter special barriers that need to be addressed. As welfare reform unfolds, the importance of examining this state by state, and indeed community by community, is becoming more urgent. Across the country disturbing stories are surfacing of mothers whose children have disabilities but whose caseworkers do not understand why it is especially hard to find child care, or why the parent of a child with emotional and behavioral problems gets called to school and thus has trouble meeting welfare work re-

quirements. Here the need to bring early intervention perspectives and poverty reduction strategies together is urgent.

Until very recently, the conversation about reducing child poverty as a tool to promote healthier families and children, particularly children with special needs, has been very muted. Advocates on behalf of those children can play a vital role in helping to sustain and expand a dialogue

that has enormous implications for their cause. A broad policy agenda related to poverty reduction is good for families, it is good for outcomes for all children, is good for the work force, and it is good for children with special needs.

JANE KNITZER, Ed.D., *and* NANCY K. CAUTHEN, Ph.D., *National Center for Children in Poverty, Joseph L. Mailman School of Public Heath, Columbia University*

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EARLY CHILDHOOD MENTAL HEALTH SYSTEMS OF CARE: POLICY IMPLICATIONS FOR STATES AND COMMUNITIES

It is widely understood that the mental health needs of very young children and their families are unique. In spite of this, there is no cohesive national public policy approach to meeting those needs. The federal legislation that does exist focuses almost entirely on children and adolescents with serious emotional and behavioral disorders. As a result, the vast majority of America's communities do not have a comprehensive system of mental health services for young children and their families (Koyanagi, Feres-Merchant & Schulzinger, 1998). All young children, including those at risk for mental disorders, those with other health and developmental disabilities, and those exhibiting emotional and mental disorders, require a range of multiple, diverse, formal and informal services and supports that are culturally competent, recognize child and family strengths, and address individual needs. An early childhood mental health system of care offers a seamless array of flexible and varied services delivered when they are needed in natural settings, such as family homes, childcare and early education programs, and primary health care offices. States and communities that wish to build and implement such a system must adopt a two-pronged approach: first, the challenges presented by fragmented and weak legislation have to be addressed, and second, they must tap

into the existing opportunities embodied in current policies.

CURRENT POLICY ISSUES

Welfare Policy—The sweeping welfare reform legislation passed in 1996 continues to have major implications for early childhood mental health initiatives. Despite legitimate concerns about potential negative impacts of welfare reform on young children, steps can be taken to utilize TANF (Temporary Assistance for Needy Families) in the development of an early childhood mental health system of care. States can take advantage of the option to exempt single parents' of infants under age one from work requirements. TANF dollars can be used in flexible ways to enhance early childhood and family support strategies, particularly when funds are transferred to the child care block grant (Knitzer & Cauthen, 1999). Many of the families involved in the welfare system have young children who are vulnerable to poor outcomes and in need of the child development support services that an early childhood mental health system of care can provide. Co-locating substance abuse and mental health services with Head Start, child care, and primary health care, helps meet the needs of families who are least able to meet the work requirements of TANF and who are sometimes difficult for welfare workers to contact. At the very least, wel-

fare policy in its current form necessitates a strong partnership between the early childhood community and public welfare agencies.

Health Care Policy: Medicaid, Managed Care, and SCHIP—An understanding of Medicaid policy is critical when building an early childhood mental health system of care because most of the services children and their families need can be funded through the Medicaid program. Many states already have reimbursement mechanisms in place for flexible services; the services simply need to be tailored to meet the needs of young children and families (Knitzer, 1996). Medicaid entitles any eligible child to screening, diagnosis, and a broad array of services. Early intervention and comprehensive services are specifically addressed in the legislation through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate (Koyanagi, Feres-Merchant, & Schulzinger, 1998).

Intertwined with Medicaid policy is the system of Managed Care. In many states, Medicaid is changing the way it operates to a managed care model in which families must use a provider who is a member of a network of approved providers, and permission for services must be obtained in advance (Koyanagi, Feres-Merchant, & Schulzinger, 1998). The development of these managed care plans can be influenced so that con-

tracts awarded to managed care organizations place an emphasis on prevention, early intervention, and interagency and system-level coordination. Health plans must be charged, in their contracts, to conduct regular and interperiodic mental health screenings and to use specialized tools that ensure adequate assessment of mental health problems. In states with separate managed mental health care plans, or "carve outs", the responsibility for providing screenings for children on Medicaid should fall to those providers (Bazelon Center for Mental Health Law, 1999).

Another important element of current health care policy is the State Children's Health Insurance Program (SCHIP) legislation created in 1997 to cover uninsured children from working families whose incomes are too high to qualify for Medicaid but too low to afford private health insurance. SCHIP provides federal funds to ensure health care coverage for children in families with incomes up to 200% of the federal poverty level in most states, and up to 250% in a few states. This increased coverage could open the door to mental health services and supports for many young children and their families. A number of states have selected the option of enrolling these children in Medicaid. However, if the Medicaid program does not incorporate the principles of an early childhood mental health system, alternative avenues of insurance coverage should be explored.

Education Policy: IDEA and School Readiness—Part C (services to infants and toddlers) and Part B, Section 619 (services to preschool children) of the Individuals with Disabilities Education Act (IDEA), is a federal special education program focusing on early intervention. This legislation can be an important point of entry for young children needing services and supports as it is clearly written to include infants, toddlers, and preschool aged children. Most encouraging, the policy itself is structurally consistent with the best principles of children's mental health service system by including family focus, multidisciplinary, and flexible services language (Knitzer, 1996). Although the law clearly provides eligibility to young children with emotional disabilities, they are very under-represented in the system. One policy analysis conducted by the University of North Carolina showed that mental health and child welfare agencies are rarely active participants on State Interagency Coordinating Councils (ICCs). While Part C allows states to address the needs of infants and toddlers at risk for disabilities, only 11 states have chosen to serve

SERVICES AND SUPPORTS IN EARLY CHILDHOOD MENTAL HEALTH SYSTEM

Services and supports in an early childhood mental health system of care can be categorized within three components:

- Services for parents, families, and caregivers of young children to help with the demands of childcare responsibilities;
- access to clinical programs and case consultation is necessary to strengthen competencies in promoting emotional development in young children, and immediate crisis intervention services are necessary for those experiencing violence, community disasters, or family-specific crises; and
- coordination mechanisms that encourage broad-based collaboration at the child and family, agency, and system levels.

Services and supports for parents, families, caregivers	Clinical programs, case consultation, crisis intervention	Fostering collaboration
Parenting skills Teen pregnancy services Quality childcare Social supports Substance abuse prevention Home visits and in-home services Playgroups with mental health support Case management & service coordination Employment assistance Consultation and training for families and caregivers Clinical supervision Nutrition Healthcare Respite services Transportation	Risk assessment Evaluation Prenatal care Pediatric services Consultation/training for interventionists Individual therapy Family therapy Substance abuse treatment Medication management Behavior management Therapeutic preschools and foster care	Provider networking Team building Cross-disciplinary training Multi-disciplinary training Systems level collaboration

that population. Fortunately, growing interest in infant mental health, early brain development, and increased behavior problems in young children has sparked the growth of new state initiatives that compliment IDEA.

The Goals 2000: Educate America Act, which became law in 1994, represents a vast policy approach aimed at improving student learning. The first goal in this Department of Education initiative is for children to enter school ready to learn. Because a child's mental health has such an important impact on his or her ability to learn and achieve success in school, the implementation of this policy could have many positive applications with respect to building or enhancing an early childhood mental health system of care. Funds are also set aside to assist in the establishment of parental information and resource centers aimed at increasing parent knowledge of and confidence in child-rearing activities and enhancing the developmental progress of children.

In addition, President Clinton has proposed the Educational Excellence for All Children Act of 1999 which is a reauthorization of the Elementary and Secondary Education Act (ESEA). Within ESEA, Title II Part C outlines a strategy for enhancing the professional development of early childhood educators. Funding will be made available to improve the knowledge and skills of instructors working with young children, particularly those in high poverty areas. Training will focus on child development, particularly children with special needs, and will be tailored to meet the particular needs of a given community's young children and families.

CONCLUSION

The federal government plays a strong role in the development and implementation of policies that impact the health and well-being of young children and their families. These policies can ensure that parents have access to a comprehensive system of services and supports, or they can work to undermine systems of care by fragmenting services and supports. Currently, there is no cohesive national public policy approach to serving our youngest citizens, and so families, agencies, and systems often encounter barriers to meeting the mental health needs of children.

Welfare reform legislation unlinked Medicaid coverage from cash assistance, resulting in many eligible children and their families not securing Medicaid coverage (Koyanagi, Feres-Merchant & Schulzinger, 1998). Existing funding streams are eligibility and diagnosis driven, making it almost impossible to create a seamless system of prevention and early intervention services. Although best practice underscores the importance of fostering relationships and promoting attachment by providing dyadic-services to both caregiver and child or to an extended family, current funding systems target services for the individual. Ongoing, regular mental health consultation to classroom teachers, child care providers and home visitors is an inexpensive alternative to more restrictive services, but consultation of this depth is almost impossible to cover with federal funds.

States and communities must act to fill the gaps created by fragmented and faulty federal policies. Fortunately, many states are providing innovative programs such as universal pre-school to low income children, home visitation programs that enhance child and family resilience and decrease the incidence of abuse and neglect, and incentives for child care providers to receive training and improve the quality of care. Increased Head Start slots for 3 year olds and Early Head Start slots for infants and toddlers are desperately needed, and funds to support mental health consultation and treatment should be appropriated. TANF must be re-examined, looking at outcomes for children whose families are impacted by mental illness and substance abuse. Child care continues to be an area in need of adequate funding, enhanced quality, and better educated and compensated staff.

Research, anecdote, and experience point out the need for a focus on the total development of the young child. Whether by virtue of environment or biology, increasing numbers of infants, toddlers, and preschool children experience or are at risk for mental illness. Public policy must better address the complex mental health needs of young children if we hope to build effective early childhood mental health systems of care.

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NOTES & COMMENTS

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CONGRATULATIONS TO:

A. Myrth Ogilvie upon successfully completing your doctoral work in Social Work at Portland State University. Her colleagues and many fans all celebrate your achievement! and to **Razif Abdrazak** upon completion of your doctoral work in Engineering. May you and your family enjoy sustained health and happiness in the future. Thank you for the wonderful work you gave to the Center while you were a student. You will be missed.

* * * *

NEW PUBLICATION AVAILABLE

The Bazelon Center for Mental Health Law and the Federation of Families for Children's Mental Health jointly published *Staying Together: Preventing Custody Relinquishment for Children's Access to Mental Health Services- A Guide For Family Advocates.*

To obtain copies of *Staying Together* or learn about other Bazelon Publications on issues affecting children visit the website at: www.bazelon.org or contact the publications desk at this location:

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SIXTH ANNUAL MEETING

The sixth annual meeting of the National Assembly on School-Based Health Care in Association with the US HHS Bureau of Primary Health Care, *School Health Programs: Healthy Schools, Healthy Communities Fulfilling Preventions Promise,* June 25-27, 2000 at the Hyatt Dearborn in Detroit, Michigan. To learn more about this meeting visit *www.nasbhc.org* or call 888.286.8727.

GREGORY FRICCHHIONE, M.D.

Gregory Fricchhione, M.D. associate professor of psychiatry at the Harvard Medical School, joined The Carter Center as director of the Mental Health Program, beginning January 24, 2000.

The Carter Center's Mental Health Program was established by Mrs. Carter in 1991. Through its annual Rosalynn Carter Symposium on Mental Health Policy and Mental Health Task Force, the program has addresssed such critical issues as: parity for mental health in insurance coverage, assuring quality in mental health care, mental health and mental illness in the workplace, privacy and confidentiality of patient information, and promoting positive behaviors in children. For more information contact: Deanna Congileo at 404.420.5108. Additional information about The Carter Center is now available on at *http://www.cartercenter.org*

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