

Task Force on the Mental Health, Social, and Emotional Needs of Young Children and their Families

Friday, June 24, 2011

North Carolina Institute of Medicine, Morrisville

10:00am-3:00pm

Meeting Summary

Attendees:

Workgroup Members: Marian Earls (co-chair), Beth Melcher (co-chair), Patti Beardsley, Karen Appleyard Carmody, Deborah Cassidy, John Ellis, Crystal Hayes, Jill Hinton, Rhett Mabry, Judy McKay, Emma Miller, Laura Muse, Susan Perry-Manning, Janice Petersen, Marla Satterfield, William Smith

Steering Committee Members: Melissa Johnson, Susan Robinson, Adele Spitz-Roth

NCIOM Staff: Kimberly Alexander-Bratcher, Thalia Fuller, Emily McClure, Arijit Paul, Sharon Schiro, Pam Silberman, Rachel Williams

Other Interested Persons: Gary Ander, Susan Cupito, Michelle Hughes, Catherine Joyner, Jeff Quinn, Betty Rintoul, Rick Zechman

Welcome and Introductions

Marian F. Earls, MD, FAAP, Medical Director, Guilford Child Health, Inc.

Beth Melcher, PhD, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, North Carolina Department of Health and Human Services

Dr. Earls welcomed everyone to the meeting.

Caregiver-Child Relationships: Laying the Foundations for a Successful Life

Betty Rintoul, PhD, Clinical Psychologist, Encouraging Connections

Dr. Rintoul underlined the importance of a child's relationship with his/her caregivers, including parents. The first couple of years of a child's brain development is centered on the limbic system—the part of the brain that focuses on emotion. This is why a positive social environment which includes loving touch, tone of voice, facial expression and responses to a child's initiations is so important in creating a foundation for a successful life. Negative experiences release cortisol, a stress hormone, which is toxic to developing brain connections.

Healthy relationships with caregivers and parents are influenced by community values and resources, caregiver/parent well-being, and caregiver/parent behavior. Community policies should focus on promoting well-being and the competence of caregivers, targeting caregiver qualities such as positive emotion, and providing active coaching and relationship support. Evidence-based interventions for the caregiver and child include child-parent psychotherapy, parent-child interaction therapy, attachment and biobehavioral catch-up, nurse family partnership (NFP), the Incredible Years program, and the Circle of Security program.

Dr. Rintoul's presentation and handouts can be found here: [Caregiver-Child Relationships](#).
[Pyramid Model Handout](#)
[Resources for Further Exploration Handout](#)

Selected questions and comments:

- The Division of Child Development and UNC-Greensboro have worked together on a study that looked at the relationship between a teacher's emotional well-being and a child's well-being. They found a strong correlation between the two.
- There is a myth that an infant is too young to remember traumatic events. However, it is through caregiver relationships that the cognitive process of understanding trauma affects the baby.
 - Babies do not express memory of traumatic events because they do not have the language to verbalize it later. The event is built into the brain. When the child reacts very negatively to something it is because he/she remembers a trauma but adults think that behavior comes out of nowhere.
- Q: If a child is exposed to trauma for a short time early in life, will a healthy relationship reverse the effects of it? A: In general, the earlier a child obtains a healthy relationship the better. However, after about two or three years of age there is more baggage and less chance of change. By five or six years of age it is much more difficult to treat a child that has been exposed to trauma early in life.
- Q: Love is a key driver in attachment. Is sending children into surrogate situations helpful or hurtful? A: For children in a negative home environment, high quality childcare is protective. For children in a high quality environment, low quality daycare seems to have less of an impact on long-term development. If there is a good environment for the child somewhere, the child will utilize it more than the negative environment.

Creating Systems to Support Evidence-Based Programs in North Carolina

Michelle Hughes, MA, MSW, Project Director, Benchmarks

Ms. Hughes gave an overview of evidence-based practices and implementation of those practices. Using evidence-based practices for intervention programs is important due to

increased accountability and cost-effectiveness. Though “evidence” is hard to define, most agree that it includes sound theoretical basis, acceptance in clinical practices, no substantial harm or risks, replicability, and shown efficacy (i.e., randomized clinical trials).

Evidence for a program is necessary, but without proper implementation even an evidence-based program can fail. When implementing evidence-based practices, there must be fidelity to the most important aspects of the program as well as certain implementation drivers including staff competency, organizational supports, and leadership. An implementation system should include the community-based implementing agency, an intermediary organization, and purveyors. The intermediary organization provides facilitation, coordination, and creation of infrastructure needed to implement the program.

Building an effective implementation system includes evidence and implementation support, a focus on intermediary functions, collaborative planning, and cost-effectiveness.

Ms. Hughes’ presentation can be found here: [Evidence-Based Programs](#).

Selected questions and comments:

- A program can be evidence-based and still not be the most effective intervention for an individual case. A clinician’s clinical judgment is also important in selecting an intervention.
- Q: Are there other entities that act as intermediary programs in North Carolina? A: The Center for Child and Family Health acts as an intermediary for parent-child interaction therapy (PCIT).

Nurse-Family Partnership (NFP)

Catherine Joyner, MSW, Executive Director, Child Maltreatment Prevention Leadership Team, North Carolina Department of Health and Human Services

Ms. Joyner explained NFP, an evidence-based and cost effective program for at-risk first time mothers. The program intervenes ideally from 16-weeks into pregnancy until two years after the birth of the child. Registered nurses, with a bachelor’s degree, visit mothers in their homes to provide intensive services focused on behavior and primary care. NFP aims to improve pregnancy outcomes, child health and development, and the parents’ economic self-sufficiency. The program is currently available in 15 counties and could be available in 51 counties by the end of 2011.

Ms. Joyner’s presentation can be found here: [NFP](#).

Selected questions and comments:

- Q: How many program sites have a specific father focus? A: The only one that has a father focus is the Guilford site.
- Q: What is the retention rate for the program? A: There are not any specific data yet on retention rates. The earlier a family begins NFP, the higher the rate of retention. If a family does leave the program, it is usually after the baby has been born. However, NFP allows families to take a break. The family can come back into the program after missing visits since the program does not kick people out for missing visits. NFP is a significant investment in time and we do not want to discourage a mother from working or finishing education, etc.

YWCA Greensboro Parenting Programs

Susan Cupito, Director of Programs, Greensboro YWCA

Ms. Cupito explained the Healthy Moms Healthy Babies program administered by YWCA Greensboro. The program has two initiatives within it: one for teens and one for adults. All teens are welcome into the teen program while the adult program targets those at high risk for poor birth outcomes. The program aims to deliver healthy school-ready children, promote proper birth spacing, and teach parenting skills and self-sufficiency, especially to teens. Critical components of the program include empowerment, comprehensive and interdisciplinary, individual support, peer support, collaboration, and a welcoming and affirming place where families are valued.

The program has resulted in improved rates of healthy birth weights, full-term deliveries, breastfeeding, vaginal births, and birth spacing. A cost savings of over \$600,000 was seen in the first year.

Policies to improve early childhood mental health should focus on integrating primary care and mental health, funding the Adolescent Parenting Program and Healthy Beginnings, supporting doula programs, supporting home visiting programs, and recognizing models that empower women and families to overcome barriers such as poverty.

Ms. Cupito's presentation and handouts can be found here: [Healthy Moms Healthy Babies](#).
[APA Integrated Health Care Handout](#)
[UNC-Greensboro Psychology Clinic Involvement Handout](#)

Selected questions and comments:

- A Family Life Council offers fathers programs. We also invite fathers to participate in the mother's programs including teen parenting programs in local schools.

- Q: What is the attrition rate for the program? A: Families usually stay in the program a couple of years. There is however a disengagement period. For instance, more participate in the childbirth program than other programs and then a couple of months down the road they will come back and continue the program in some capacity.
- Q: Is there a statewide YWCA or YMCA association that can disseminate the program throughout the state? A: No. The program is being replicated in part by the Raleigh YWCA. Some other Y's in the state and across the nation are beginning to replicate parts of our program.
- Programs cost \$1,200-\$1,500 per participant per year.
- Q: What transitional programs are there for teens in the program going into adulthood? A: The program addresses transitions both in group meetings and individually. The program helps parents prepare for jobs so they can be self-sufficient. Also, teens can enter the adult program to continue services.

Engaging Beyond the Mother-Infant Dyad

Karen Appleyard Carmody, PhD, Clinical Associate, Department of Psychiatry and Behavioral Sciences, Duke University Medical Center

Jeff Quinn, MPH, Research Analyst, Center for Child and Family Policy, Duke University

Dr. Carmody discussed the role of positive social support on child development. The Minnesota Longitudinal Study of Parents and Children (MLSPC) found most children's social support is provided by the biological father and grandparents. Social support was generally frequent and constant, of varying quality, and had a lot of disruptions in who provided care. Children with higher quality and quantity social support, and with a low number of disruptions, had fewer internalizing and externalizing problems. Based on the MLSPC results, interventions for social support should work to enhance quality and minimize disruption.

Mr. Quinn discussed the importance of the father on a child's socio-emotional development. Fathers have a different impact on the child than mothers. Positive father engagement improves social and cognitive development. Fatherhood engagement should begin prenatally and quality interaction is better than quantity. Barriers to father engagement include social norms, low amount of research, and mother-centric childhood development programs. Policy development to increase father involvement should focus on using programs with promising research, beginning programs prenatally and encouraging co-parenting, including fathers in promotion of child development, using programs that address all levels of the socio-ecological model, and assessing whether agencies are father-friendly.

Dr. Carmody and Mr. Quinn's presentation can be found here: [Beyond the Mother-Infant Dyad](#).

Selected questions and comments:

- A father's role tends to be seen as an obligatory role (i.e., financial, legal, etc) rather than a child development or care giving role.
- Q: What about the impact of mothers' resisting father involvement? Social norms imply that dad does not need to be involved. In addition, some moms may not know who the dad is or do not want the dad around. It is another issue altogether.
- While mom is recovering from childbirth in the hospital, the medical staff tends to reach out to dad. That can be a lesson that can be expanded to other programs.
- Q: Is it better to have a dad involved when there is a issue of abuse or is it better for a dad not to be involved? A: If dad is an abuser or has other issues the definition of what a dad is can be expanded. Maybe grandpa or a mom's friend can fill the role of father. That tends to be a better situation than having an abusive dad.

Discussion of Potential Recommendations

The workgroup discussed potential recommendations. The ideas & topics included the following:

- Messaging/Communication
 - Use common framework for communication and education: brain architecture framework.
 - Development is not just academics. Socio-emotional development is important, too.
 - Build on framework of NC Framing Community
 - PSAs – for promoting social change
 - Be sure messages are tested.
 - Look at messaging work for WV and FL.
 - Need to communicate financial savings to Legislature. Since terms are short (2 years), need to focus on 1-year savings.
 - Coordinate PR campaign with Early Child Advisory Group. Messages should be the same.
 - Use term “parents” vs just “moms”. Need to include fathers.
- Assessment – Qualifying for programs
 - Change criteria to include s-e delays, not just physical and cognitive delays. Policy may already exist, so may need to focus on consistent implementation.
 - Education on assessment of s-e delays for child-care workers, social workers, DSS.
- Programming
 - Integrate S-E component to all programs geared toward age 0-5 – but especially for age 0-24 months.

- Expand Medicaid coverage to support assessment & care/referral of parents as well as child in pediatric visits
- Foster care
 - Specialized foster care certification for 0-5
 - Incorporate training on s-e development in to foster parent training
 - Frequent moves of child between foster homes may adversely impact s-e development – unstable environment, attachments.
 - Need to work with DSS to reduce # of moves, especially age 0-3.
 - Training for court system: examples: Infant MH court (Guilford Co), Koala Boundary (Cherokee Indian Reservation)
- Child care
 - Same teacher for age 0-5? To provide stability, consistency in attachment
 - Provide high quality child care - that provides appropriate child-caregiver interactions
 - May require training of child-care providers on appropriate interactions for building s-e health
 - Provide programming on building parent-child relationships in all child-care settings so available to all parents & children.
 - Removes requirement for deficit prior to intervention.
 - E-B
 - Example: “Promoting Healthy Social Behaviors”, “Incredible Years”, DECCA, PCIT
- Caregiver – child relationships
 - Promotion of parental role as including physical, behavioral, and emotional care
 - Improve parent-child relationships
 - Education with coaching and support on parenting skills, positive child-parent interaction, age-appropriate development and interactions, emotional attachment
 - Gentle, responsive nurturing
 - Clear, consistent expectations, supervision
 - Positive and responsive verbal interaction
 - Stable environment and caregiver
 - Focus on co-parenting
 - Target caregiver behaviors of warmth, sensitivity, and positive emotion
 - Promote continuum of relationships vs all-or-none
- Fathers
 - Engage fathers
 - Start prenatally
 - Focus on quality vs quantity
 - How?

- Resources and programs– development and promotion. Who?
 - Improve paternal-friendly nature of agencies
 - Programs to recruit and retain fathers in services. Examples?
 - Change social norms regarding father’s role. How?
 - Public education/awareness., Messaging.
 - Education and coaching on emotional attachment
 - Collaboration
 - Socio-ecological framework – working at 5 levels
 - Barriers?
 - Social norms – primary parent; nurturing behavior
 - Most research focused on moms. Dads are different.
 - Lack of programs for fathers.
 - Multiple risk factors and all-or-nothing framework
 - Organizational change – staff bias
 - Programs
 - Specifically for fathers – vs modification of mom’s programs
 - Recruitment
 - Flexible hours
 - Father-to-father
- Healthy caregivers
 - Improve health of parents and frequent caregivers: physical, mental, reduction of substance abuse, birth spacing, life planning, nutrition
- Environment
 - Provide healthy, supportive, predictable, stable environments (home, neighborhood): space, play materials, noise, social supports, friends
 - Social supports: quality, quantity, lack of disruption
 - Barriers: Homelessness, domestic violence
 - Train parents on preparing children for transitions to minimize impact
 - Improve parents’ economic self-sufficiency to minimize transitions
 - Life course development, financial literacy, dress-for-success, business environment
- Evidence-based practices
 - Provide support to communities, agencies, and practitioners for implementation of e-b practices with fidelity
 - Implementation infrastructure
 - Assessment of existing capabilities of agency/community
 - Tools, resources, technical assistance
 - Coaching: on-going support
 - Evaluation, Quality improvement, Data
 - Fund programs with assurance of infrastructure

Public Comment Period

No further public comments were given.