Yoshikawa, H., & Knitzer, J. (1997). Lessons from the field: Head Start mental health strategies to meet changing needs. Executive summary. New York: National Center for Children in Poverty.

Executive Summary

Lessons from the Field: Head Start Mental Health Strategies to Meet Changing Needs highlights promising strategies generated by Head Start programs to better meet the changing and intensifying mental health needs of Head Start children, families, and staff. It is intended to foster program-to-program learning from within the Head Start community about how programs infuse a mental health perspective into Head Start. It is also designed to stimulate an open dialogue about difficult issues that are often unaddressed, such as skepticism about traditional mental health strategies, or the depth of need among some Head Start families, or where to find funding. Finally, *Lessons from the Field* is intended to spur communication and collaborative partnerships between the mental health and the Head Start communities, as well as others such as family support programs or substance abuse providers working with low-income families with complex needs.

Lessons from the Field is an outgrowth of the work of the Task Force on Head Start and Mental Health, which was convened in 1994 at the request of Edward Zigler, then president of the American Orthopsychiatric Association and a founder of and long time advocate for Head Start. The Task Force, chaired by Jane Knitzer, issued a report entitled *Strengthening Mental Health in Head Start: Pathways to Quality Improvement*. This publication explicitly called attention to the mental health-related challenges that the Head Start community is facing, the lack of information about how the field is coping with these challenges, and the inadequacy of the training and technical assistance related to mental health issues from either the larger Head Start or mental health communities.[1]

The focus of *Lessons from the Field* is on how Head Start programs are coping with the mental health-related challenges they face. The Executive Summary highlights the framework that guided the research, the data gathering strategies, and the findings. It includes a summary of program and fiscal mental health strategies identified, as well as the lessons learned and their implications for policy, practice, and research. Chapter 1 summarizes the reasons that new attention to building nontraditional and strengthening traditional mental health strategies in Head Start is both critical and possible. Chapter 2 presents mental health-related strategies that focus on staff development involving primarily work with children. Chapter 3 highlights mental health-related strategies that focus on new ways of engaging families, particularly those with the most complex constellation of stresses. Chapter 4 describes those few programs whose mental health-related strategies include strong connections to the larger community, either through collaborations around integrated services, or as part of community efforts to address problems such as substance abuse. Chapter 5 focuses on issues that are integrally related to efforts to enhance mental health in the context of Head Start. These include assessment, gaps in research, financing needs, and the

kind of training and technical assistance all programs need to enhance mental health-related strategies. Chapter 6 summarizes the lessons learned, as well as recommendations and implications for the future, at the program, community, state, and national levels. Throughout the report we use boxes to provide details on how a strategy works, on topics of practical interest, or on how strategies have affected particular children and families.

The Rationale for Greater Attention to Mental Health in Head Start

Philosophically, since Head Start began, it has maintained a commitment to mental health as an integral part of a child development orientation. In this context, mental health is defined broadly as promoting the healthy emotional development of children, supporting family strengths, identifying early signs of emotional and behavioral difficulties, and assisting families with special needs. Translating this vision into practice, however, has been problematic throughout Head Start's history.[2] This has been so for reasons which are as relevant today as in the 1970's.

- Mental health services are defined narrowly as therapy, either for children or families. Yet there is great skepticism about how effective such therapy is for Head Start children and families.
- There is a reluctance to label more troubled children as having emotional or behavioral problems.
- There has not been a well developed system for providing the Head Start community with technical assistance around how to implement responsive mental health strategies.
- Research has not highlighted the impact that different approaches to infusing a mental health perspective in Head Start have on outcomes for children, families, staff, or on program quality as a whole.
- It has been difficult for Head Start program directors and others to find, or pay for, mental health consultants who have expertise in working with young children and/or low-income families.

While these realities have been constant throughout Head Start's history, four sets of reasons make this an important time to escalate the dialogue at the community, state, and national levels about the role of mental health in Head Start.

Increased Stress

The first set of reasons has to do with the level of stress and need among Head Start children, families, and staff:

- Staff report that children are showing more and more evidence of stress in the classroom, with a significant number exhibiting withdrawn, aggressive or "out of control" behaviors that challenge the staff and sometimes threaten the overall classroom climate.
- A significant proportion of families with children in Head Start have intense and complex needs. Community and family stresses such as substance

abuse, domestic violence, HIV/AIDS, unemployment, depression, and community violence combine for many parents in ways that affect their ability to engage with their children and with Head Start programs.
- Head Start staff, too, must cope with difficult stresses. For some, there is burnout related to the depth of need that they see. Others are coping with difficult realities in their own lives not unlike those facing the Head Start parents and children.
- As Head Start becomes increasingly multi-ethnic, staff face enormous challenges in not only finding creative ways to strengthen respect for the different cultural backgrounds reflected in the children and families, but also in resolving work-related cross cultural conflicts (such as the tensions reflected in different expectations about child rearing and discipline).
- Children with serious emotional and behavioral problems appear to be under identified in Head Start. Program Information Reports from the 1994–1995 year suggest that only two-thirds of one percent of Head Start children are identified as having such disorders. But careful studies have estimated that a much larger percentage of the children could benefit from some form of planful intervention.

New Developments in Children's Mental Health

The second set of reasons for reemphasizing the role of mental health in Head Start has to do with new developments in children's mental health which have resulted in the creation of "systems of care" to serve largely older, troubled children and adolescents. These systems of care are characterized by:

- A commitment to family-centered mental health and related services, with parents as partners in the decision-making and treatment process for their own children, as well as participants in larger governance strategies.
- A belief that children, even those with emotional and behavioral difficulties, should have as many opportunities as possible to participate in age appropriate activities in normal settings, with whatever supports are necessary.
- A commitment to use mental health dollars flexibly to respond to what families need, not just what mental health providers have traditionally offered (outpatient treatment, day treatment or placement in residential settings). Thus, mental health dollars have been used for home- and school-based services, including intensive in-home therapies, respite care, mentors, and coaches. This fiscal flexibility supports clinical flexibility in responding to family needs.
- A recognition that mental health services alone, without the support of other agencies, rarely works. This has led to efforts to work collaboratively with other community agencies, including the schools, child welfare agencies, and the early childhood community, on behalf of children with behavioral and emotional problems.

These four tenets are parallel to the core Head Start philosophy—a commitment to parent involvement; a belief in the power of integrating

children with special needs in Head Start settings, a flexible approach to services, and a recognition of the importance of working with other community agencies and leaders, offering new opportunities for collaboration at the program and training level. However, to date, there has been only a limited effort to expand system-of-care concepts to Head Start, and many in the Head Start community are unaware of these new developments. This appears to be changing, with new interest in early intervention and prevention reflected in community-based mental health initiatives on behalf of young children and families.[3]

New Opportunities in Head Start

The third cluster of reasons to focus new attention on mental health in the context of Head Start has to do with renewed interest from the Head Start community in addressing issues of quality. This includes a greater focus on the role of mental health within the context of Head Start, illustrated by the attention paid to mental health in the newly promulgated Head Start Performance Standards.[4] Unlike previous standards, these emphasize the importance of having a mental health consultant on-site frequently enough to build a relationship with staff and families. Such standards provide the necessary (although not sufficient) context to encourage the development of more effective mental health strategies, particularly in the face of increased family stresses.

Lessons from Research

A growing body of child- and family-related research indicates that intervening in the lives of at-risk children can help reduce the level of later problems, such as school dropout or delinquency. The key to successful interventions seems to be intensity and quality of services, as well as attention to *both* family and child. By offering intensive services to both parents and children, these programs seem to have affected a range of family and child delinquency risk factors, as well as antisocial behaviors and delinquency itself. Strengthening mental health supports to children, families, and staff is one way of enhancing the intensity of support offered to children and families, and hence its potential impact.

For these reasons, then—the urgency of the need, the emergence of a new children's mental health orientation consistent with the Head Start philosophy, new interest from the mental health community in prevention and early intervention, recognition from within Head Start about the need to focus on mental health—*Lessons from the Field* offers insights upon which to build new directions and initiatives, both for the Head Start community and for the larger early childhood community.

The Questions and Assumptions that Guided *Lessons from the Field*

Based on the review of the literature and the work of the Task Force, eight questions guided our effort to emphasize deliberate, goal-oriented strategies.

- How can planning within Head Start and with other community agencies be a tool to infuse a mental health perspective throughout the program?
- What strategies are programs using to enhance teacher skills in working with children whose behaviors are troublesome, or frustrating? Children with other special needs? Crisis situations?
- What strategies are programs using to enhance the skills of family support/ service staff and home visitors?
- What strategies have programs found effective in engaging families with different combinations of strengths and needs?
- How do programs work directly with individual children experiencing difficulty? With families experiencing multiple stressors?
- In what ways do programs ensure that mental health consultants are integrated into the Head Start program?
- What kinds of services are appropriate for young children exhibiting seriously troubled behaviors?
- How is it possible to pay for the kind of mental health services that seem to make sense when most mental health dollars are only for traditional treatment?

How the Information was Gathered

Lessons from the Field used three strategies to identify the programs described. First, we encouraged self-nominations from Head Start programs, placing a call in the National Head Start Association Journal, which is sent to all Head Start programs. In addition, we sent out mailings to solicit names of programs from key informants, including leaders in the Head Start community, regional office staff, and members of the Task Force on Head Start and Mental Health of the American Orthopsychiatric Association. Finally, we attended conferences such as the annual meeting of the National Head Start Association to identify programs engaged in improving mental health and family support.

This resulted in the identification of 73 programs, partnerships, and initiatives within Head Start, including programs which referred themselves. Staff at all of these programs were contacted, either by phone or through site visits. Information was gathered on: (1) the nature of the program and its focus on mental health; (2) the geographic location and community served, including suburban, urban, and rural areas, number of families served, and cultural and ethnic backgrounds of families served; (3) the history of the initiative, including first impetus, development of collaborations, if any, funding strategies, initial efforts and how they subsequently developed or were revised; (4) the impact of the initiative on staff, parents, and children.

In the second stage of the project, we reviewed the information on the 73 programs to winnow them down to a more manageable group. Fourteen programs which best illustrated general strategies and approaches to improving mental health in Head Start, and which represented a diversity of geographic areas and populations served were chosen for more in-depth interviews and site visits. A variety of key informants were contacted at these

programs, including Head Start staff, administration, parents, and key members of other participating agencies (such as local mental health agencies). Of the 14 programs, 7 were visited. Information gathered included in-depth data on the issues explored in the initial scan, as well as vignettes illustrating each program's effects on Head Start children, parents, and/or staff. (Several additional programs are briefly mentioned in sidebars.)

All of the final program descriptions were reviewed by the programs. (In some instances, we removed identifying details about staff or families.) In addition, a draft of the entire report was shared with members of the Head Start community and of the Task Force for review.

How the Report Can Be Used

This report is intended to be useful to program directors who have to use scarce monies to meet mental health requirements, and to mental health coordinators and consultants as they grapple with how best to use limited time and gain the most impact. But the report also has implications for those at the state and national levels. It is particularly relevant to those developing strategies to help the field implement the revised performance standards that provide a new emphasis on mental health. We hope, too, that the report will be useful to those administering the Head Start State Collaborations (now in almost all the states), and especially to Head Start, mental health organizations, family support providers, and others involved in the increasingly collaborative community-based efforts to build integrated systems of care for young children and families.[5] Finally, we believe the report has implications for researchers who have long ignored, but seem to be increasingly recognizing, the importance of the mental health aspect of the Head Start program and the significance of behavioral and emotional well-being of young children for future school success.[6]

The Key Findings

The 14 Head Start programs profiled in this report engage in mental health strategies that focus on staff development, on families, and, to a lesser extent, on community-level collaborations. Most use mental health consultants to facilitate the development of a coherent approach to the children and the families, and to help staff develop more mental health-related skills, as well providing more traditional services. Across the programs the following themes emerged.

- Staff support and skill development related to mental health can take many forms. Programs are using strategies ranging from classroom mentoring and coaching, to supervision enriched with a mental health perspective, to access to career ladders and community credentialling programs, to peer support for those working with difficult-to-engage families.
- Directors and mental health coordinators report that staff support and mental health-related skill development pay off in multiple ways: better problem solving skills, greater staff confidence in coping with difficult situations, a wider range of concrete strategies to help children and families, and the provision of a safety valve which enables staff to share the frustrations as

well as celebrate the victories of their work. All of these factors can help create and sustain the kind of caring culture that is the hallmark of Head Start.

- For families, on-site, family supportive, non-stigmatizing services are less threatening than the usual referral for therapy. Parent groups, for example, help families feel more comfortable talking about problems, asking for help, and seeing strengths. Sometimes this is enough. Sometimes, it makes families more willing to accept traditional mental health services if they need them. Linking parents with family support programs can occur either by bringing family support programs on-site, or by building parent-to-parent support within Head Start.
- Mental health strategies in Head Start work best if they are tailored to community and cultural meanings of mental health. Sensitivity to the particular attitudes, strengths, and resistances to mental health which may be present in a community requires a willingness to revise and adopt strategies that best fit the families served by the Head Start program.
- Infusing a program with family-focused mental health strategies requires a shared vision that takes time to develop. It may also require a shift in how staff perceive families' strengths and what their lives involve. Programs report that mental health strategies that start by responding to family concerns pay off, but that using strength-based, family-centered service strategies requires significant staff- and director-level support.
- Effective family-focused mental health strategies in Head Start involve all staff crossing sometimes rigid component boundaries among mental health, social services, and parent involvement.
- Organizing communities to address problems can be an effective component of Head Start's efforts to deal with seriously troubled children and/or families with severe challenges, such as substance abuse. However, although 6 of the 14 programs report collaborations with local community mental health centers, only two of the programs report serving the most seriously troubled children using community-based system-of-care principles. Only one reported using community organizing as a strategy to complement more direct work with substance-abusing families (and that as a result of a foundation-supported initiative).
- Implementing a holistic and deliberate mental health strategy that goes beyond observations and referrals takes time. In many cases the process starts with trial and error, and then evolves into an approach that fits the needs of the programs. Fiscal creativity is often required, such as maximizing Medicaid, pooling Head Start dollars across components, or using quality improvement funds.
- There is woefully little evaluation to guide the choice of one mental health-related strategy over another, or even to help program directors and management staff envision the potential strategies. The choice is often a matter of chance, based on what approaches and/or resources a particular program can access. Anecdotally, many programs reported increased parent involvement, or improved classroom environment as staff competence in meeting the needs of challenging children or helping families address complex issues increased. Empirically, however, there is little data to guide the field.

Six Lessons from the Field: The Message at a Glance

- Focusing on the strengths of children and families is core to the Head Start philosophy, but is sometimes hard to do, especially when families have complex needs, or children engage in provocative behaviors.
- Often the most effective ways of helping young children are indirect; for example, having mental health consultants work with the teachers or parents to change their perspectives or approaches to the child, rather than working directly with the child.
- Often the most effective way of engaging parents stressed by chronic poverty, violence, depression, or substance abuse is to start where they are, helping them to address whatever is most important to them—even if it is not child-related. Offering child-focused mental health services in a vacuum often does not work.
- Paying strategic, deliberate attention to the emotional and behavioral issues facing children, families, and staff is crucial to having a quality Head Start program.
- Ongoing, trusting relationships among consultants (or staff members) with mental health expertise, staff, and families are critical. The mental health consultant must be a familiar part of the program.
- Children who do exhibit serious emotional and behavioral disabilities should be linked with system-of-care efforts through mental health agencies that include both families and Head Start as critical partners in the treatment effort.

What Mental Health Means in the Context of Head Start

Mental health strategies cited in this report share five characteristics. They are:

- *Focused on family and staff, as well as on children,* in recognition that healthy adult-child, as well as peer relationships are a key foundation for social and emotional competence in young children;
- *Strength-based,* with a philosophical value orientation toward identifying strengths, as well as challenges facing families and individual children
- *Practical,* with an intent to embed a mental health perspective into the day-to-day challenges Head Start families face (e.g., helping homeless families deal with the transition to kindergarten; preparing parents for meetings with managed care providers);
- *Clinically and culturally sensitive,* grounded in understandings of the complexities of need, stress, and behaviors as they affect families from diverse cultural backgrounds (e.g., encouraging cultural expression in a parent support group for African American mothers);
- *Open to new kinds of partnerships:* (for example, including parents in staff trainings; working with supervised interns from mental health agencies); and
- *Realistic about the need for deliberate strategies to make mental health "user friendly"* (for example, calling mental health consultants "early interventionists," providing on-site services to families in a familiar setting, using parent support groups to help engage families; addressing the fear that mental health is only for those who are crazy or is irrelevant to the lives of families who day-to-day struggle with urgent survival issues).

Where to Find It: A Guide to Mental Health Program and Fiscal Strategies Highlighted in *Lessons from the Field*

To develop an overall approach to mental health, mental health coordinators and program directors or delegate agency directors report:

- Creating an interagency planning committee focused on mental health that includes key leaders from the community, e.g., parents, school superintendent, chair of mental health board, outreach director for health and mental health managed care organizations serving the community (Ulster County, Chapter 3).
- Using the mental health subcommittee of the Health Advisory Committee (Ulster County, Chapter 3).
- Participating in community-wide collaborations to plan for and integrate services for young children and their families through family resource centers, and service integration efforts (Hawkeye Area Head Start, Chapters 3 and 4).
- Carrying out internal assessments with program staff and families (many programs).

To enhance mental health-related competencies in Head Start staff, mental health consultants collaborate with staff by:

- Offering in-classroom coaching and mentoring (Nassau County, Chapter 2).
- Facilitating teacher support groups (Nassau County, Chapter 2).
- Participating in and being a consultant to routine staff meetings (Nassau County, Chapter 2; St. Bernard's, Chapter 2).
- Facilitating group consultation and support to home visitors and/or family service workers (Rosemount Head Start, Chapter 2).
- Facilitating peer support meetings with family service workers (Head Start Parent Involvement Project, Chapter 3).
- Facilitating classroom or cross-component team meetings (Hawkeye Area Head Start, Chapter 3).
- Providing individual consultation to the director and staff (Nassau County, Chapter 2, and many of the other programs).
- For programs with multiple sites and multiple consultants, convening a network of mental health consultants and providing periodic support meetings (Action for Boston Community Development, Chapter 3).

To help individual children in the classroom, mental health consultants in Head Start are collaborating with staff by:

- Using teacher-friendly, validated screening for children's emotional and behavioral development as a tool to help teachers as well as children (Early Screening Project, Chapter 5; Ventura County, Chapter 5).
- Providing one-on-one in-classroom consultation on specific children, problem-solving with teachers to develop interventions (Nassau County, Chapter 2; St. Bernard's, Chapter 2).
- Helping to implement classroom prevention strategies (Choosing Non-Violence, Chapter 2; Management and Prevention Project, Chapter 2).
- Working with teachers to integrate mental health into classroom curricula, e.g., using stories to discuss such difficult issues as violence and grief (St. Bernard's, Choosing Non-Violence, Chapter 2).
- Using specially trained volunteer students to work with individual children (Jumpstart, Chapter 2).

To enhance strategies to engage and help families, Head Start staff and mental health consultants are:

- Helping staff examine their assumptions about families, enhancing their skills in identifying and building on family and cultural strengths (Nassau County, Chapter 2; Resiliency Partnership-Directed Intervention, sidebar in Chapter 3; Hawkeye Area Head Start, other programs as well).

(Where to Find It, continued)

- Identifying mentor parents, who provide extra support to isolated, hard-to-engage, or stressed parents (Hawkeye Area Head Start, Chapter 3; Resiliency Project, sidebar in Chapter 3; Free to Grow and Community Partnership for Child Development (CPCD) Head Start, Chapter 4).
- Helping families create a resource exchange to share skills (Hawkeye Area Head Start, Chapter 3).
- Using staff and mental health consultants to enhance parenting skills in a family friendly way (Partners Parent Training, sidebar, Chapter 3).
- Using parent support groups to enable parents to discuss issues of most concern to them at their own pace. Remaining on the alert for serious problems (e.g., clinical depression, suicidal behaviors) (Ulster County, Chapter 3; Resiliency Project, sidebar in Chapter 3).
- Helping families with the transition to school, especially when parents own school history has not been positive, e.g. rehearse parent-teacher conferences (St. Bernard's, Chapter 2).
- Opening staff training sessions on mental health-related topics to parents and other caregivers (many of the programs).
- Developing targeted strategies for specific groups of families, e.g., hard-to-engage families or families involved with substance abuse (Head Start Parent Involvement Project, Chapter 3; Resiliency Project, Chapter 3, sidebar; Free to Grow and CPCD Head Start, Chapter 4).
- Providing families of children showing serious behavioral or emotional problems with access to nontraditional mental health services, such as respite care or in-home therapy (Stark County, Chapter 4).

To expand training opportunities related to mental health, Head Start programs are:

- Providing Head Start as a training site for social work and psychology interns. (Supervision can be provided either by the Head Start program, if necessary hiring a qualified supervisor with Head Start funds, or by a local mental health center or other approved training site (Ulster County, Chapter 3).
- Providing Family Development Certification courses for Head Start staff (Hawkeye Area Head Start, Chapter 3).
- Building career ladders for staff interested in family support and mental health, working with local community colleges or other training institutions (Action for Boston Community Development (ABCD), Chapter 3).
- Developing courses in conjunction with local community colleges in family support/ mental health (ABCD, Chapter 3).

To maximize dollars and resources for mental health-related activities, Head Start programs are:

- Collaborating with mental health centers to maximize the use of Medicaid dollars (Ventura County, Chapter 5).
- Networking with managed health and mental health care providers (St. Bernard's, Chapter 2; ABCD, Chapter 3).
- Developing jointly-funded projects with local community mental health and family support agencies (Nassau County, Chapter 2; St. Bernard's, Chapter 2; Stark County, Chapter 4; Ventura County, Chapter 5).
- Encouraging states to facilitate Head Start/Medicaid collaborations (sidebar on state-level Head Start/Medicaid collaborations in Chapter 5).
- Working with children's mental health advocates to increase mental health dollars targeted for early childhood mental health initiatives (Stark County, Chapter 5).
- Pooling Head Start funds to hire mental health professionals (ABCD, Chapter 2).
- Using volunteer mental health professionals (Rosemount, Chapter 2).
- Using well-supervised psychology and social work interns (Ulster County, Chapter 3).

Lessons and Recommendations

Lessons from the Field has three central messages:

1) Many Head Start programs take a very narrow view of mental health, (partially to comply with current requirements, partially by default), which does not really meet the needs of the staff, the families, or the children. The goal of the programs highlighted here is to create a holistic vision in which mental health strategies work in the service of staff, families, and children in a coherent manner.
2) Embedding new approaches to mental health in the context of Head Start is difficult. There are no quick fixes or even quick answers to enhancing the capacity of Head Start to better support the emotional and behavioral well-being of families and children living with many risks and stressors. None of the programs described is fully satisfied with where they are; all are in process, and all have faced many bumps and challenges along the way in terms of finding the right people, the right approach, and stable funding.
3) Despite the important work of the programs we learned about over the course of this study, and no doubt many others that we did not identify, well-developed mental health strategies that can enhance the success of Head Start programs are now too limited, too unevaluated, and too unsupported with training and technical assistance.

The recommendations below frame an action agenda to meet the challenges set forth in this report.

What Can Be Done at the Head Start Program and Community Level

Integrate a mental health perspective into all parts of the Head Start program.

- Move from an "on-call" to an "on-site" role for the consultant.
- Expand the consultant's role to include home visits and participation in staff and management meetings and staff-development activities.
- Integrate the mental health/family support perspective into all activities of the program.
- Use planning strategies to help Head Start directors and management teams envision and develop strategic mental health approaches that strengthen the quality of the program and the capacity of each program to respond to the level of stress among Head Start children and families.

Empower and support staff while building their mental health expertise.

- Involve the consultant in regular management and/or cross-component meetings and activities.
- Support the well-being of staff.
- Encourage and facilitate opportunities for staff to explore cultural and ethnic differences, including those regarding discipline, in ways respectful of families and Head Start staff.
- Ensure that training curricula related to mental health competencies are not "one-shot" workshops, but provide ongoing support.

- Develop career ladders for staff interested in mental health/family support.
- Make use of Family Development credentialling programs, if available.

Be sensitive to the community and cultural meanings of mental health.
- Work with families and use community planning mechanisms to explore cultural issues related to mental health.
- Let families get to know the mental health consultants at a location where the families, children, and staff feel comfortable.
- Include explicit support of cultural traditions in efforts to promote wellness and cope with stress in families.
- Use explicit strategies and language to make mental health "user-friendly."

Tailor screening assessments and service strategies to levels of need.
- Use screening and assessment tools that have been tested and validated on Head Start children.
- Work with mental health consultants and teachers to target intensive services to those children in each classroom who show the most challenging behaviors.
- Adapt mental health strategies to the intensity of needs and strengths present in families served by the program.
- Use a "system-of-care" approach to meeting the needs of the most troubled children and families, including flexible support services such as one-on-one coaches and respite care.

Develop community connections to enhance strategic mental health initiatives.
- Take advantage of windows of opportunity to start or improve collaborations with mental health, family support, and substance abuse programs as well as community-based organizations working to address community problems.
- Forge partnerships with mental health training programs.
- Take advantage of Medicaid services and the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program.
- Join in community planning efforts to create early childhood systems-of-care and/or comprehensive family support centers.
- Work with managed care providers to develop early intervention and outreach strategies for Head Start.
- Explore ways to help the most stressed Head Start families meet welfare-to-work requirements, building on effective mental health and family support strategies.

What Can Be Done at the State and National Level to Strengthen Mental Health Approaches in Head Start

Include mental health in the regional offices and the training and technical support system.
- Use the regional and national training and technical assistance system to help Head Start programs choose and use mental health consultants more

effectively, build staff mental health competencies, strengthen the intensity of family service work and use the newly promulgated Performance Standards as an opportunity to help programs plan for more responsive mental health strategies.
- Establish a staff position (or, at minimum, an advisory team) with expertise in mental health in every region to help programs and/or grantee agencies develop mental health strategies responsive to the needs of staff and families.
- Develop a system to track mental health approaches and strategies, as well as amount of service provided.
- Organize meetings of mental health consultants and coordinators in each region to share information about effective strategies.

Develop statewide collaborations for mental health in Head Start.
- Continue and expand the Head Start/State Collaboration Projects, and ensure that mental health issues are addressed by them.
- Develop Medicaid/Head Start and Part H/Head Start collaborations sensitive to the particular characteristics of these programs in each state.
- Encourage statewide meetings of Head Start mental health and family support/service staff with mental health consultants.

Provide strong national leadership.
- Gather routine information on mental health approaches used by Head Start programs.
- Create a nationwide model career ladder for Head Start staff interested in social services, family support, and mental health, and develop systematic internship strategies.
- Expand the pool of culturally-responsive mental health professionals in Head Start by developing well-structured volunteer initiatives in conjunction with mental health professional organizations.
- Provide ongoing support to programs to implement deliberate, holistic mental health strategies to meet the objectives of the proposed Performance Standards.
- Build links with ongoing national efforts, such as Start Healthy, Stay Healthy, mounted by the Center on Budget Policy and Priorities, to ensure that eligible children in child care settings, including Head Start, are enrolled in Medicaid and thus are able to access mental health as well as physical health services.
- Test strategies to apply research-based knowledge to strengthen the capacity within Head Start to prevent emotional and behavioral problems in children.

Support mental health-related research efforts.
- Incorporate measures on behavioral and emotional outcomes, as well as risk and protective factors, in all research carried out on Head Start populations.
- Explore how the Head Start experience, in general, affects emotional and behavioral patterns in children.
- Explore the effects of different combinations of mental health strategies in Head Start on all children, on children at risk of developing conduct disorder and other emotional and behavioral problems, on children with identified

emotional and behavioral disorders, and on families with different levels of stress.

- Conduct studies to determine the prevalence of serious emotional and behavioral disorders in young children served by Head Start, the prevalence of combinations of risk and protective factors that affect the development of such disorders, and variation in these disorders and factors across different kinds of communities.
- Examine the impact of managed mental health care on the delivery system for mental health in Head Start.

The message from the field is clear. The need to pay greater attention to mental health-related issues in Head Start is urgent; the strategies are emerging; and the opportunities to build a more coherent response over the coming years are too important to be ignored. *Lessons from the Field* suggests concrete, cost-responsive directions forged program by program through trial and error. Implementing these new directions more broadly will require public leadership by government at the federal, state, and community levels, as well as public-private partnerships. It will involve some new resources and redirection of existing resources. It will also require capitalizing on the positive aspects of devolution—greater flexibility at the state and community levels—and of managed care. But the task is achievable, the need compelling, and the vision becoming clearer.