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J Am Psychiatr Nurses Assoc 2007; 13; 313
DOI: 10.1177/1078390307306996

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Promoting Mental Health in Early Childhood Programs Serving Families From Low-income Neighborhoods

Susan M. Breitenstein, Deborah Gross, Irmaleticia Ordaz, Wrenetha Julion, Christine Garvey, and Alison Ridge

Although the majority of young children growing up in low-income communities will not experience mental health problems, a proportion of children will develop problems that can be painful for families and costly to society. There is growing consensus that preventive interventions in the first 5 years of life are the most cost-effective strategy for reducing children's mental health problems. The purposes of this article are to (a) present the case for providing health promotion and preventive interventions to economically disadvantaged parents of young children as standard practice in early childhood programs and (b) describe the feasibility and utility of incorporating mental health promotion services in child care centers serving low-income families using the Chicago Parent Program (CPP) as an example. The CPP is an evidence-based intervention designed in collaboration with low-income, ethnic minority parents to promote positive parenting skills and reduce behavior problems in young children. J Am Psychiatr Nurses Assoc, 2007; 13(5), 313-320. DOI: 10.1177/1078390307306996

Keywords: parent training; ethnic minority; prevention; early childhood programs

Every child has the right to a healthy start in life. However, children are born into families with very different strengths and challenges. For example, growing up in the context of a warm and responsive family and living in a safe and supportive neighborhood is

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The authors gratefully acknowledge the early childhood centers and families that participated in our studies and support of a grant from the National Institute for Nursing Research, R01 NR004085.87.

associated with healthier social and emotional development (Black & Krishnakumar, 1998; Pettit, 2004; Youngstrom, Weist, & Albus, 2003). However, poverty, single parenthood, and living in unsafe and under-resourced neighborhoods make parenting far more stressful and challenging, increasing the risks for poorer social and emotional outcomes in young children (Ackerman, Brown, & Izard, 2003; Gorman-Smith, 2003; Sameroff, Seifer, & McDonough, 2004; Youngstrom et al., 2003). Social and emotional difficulties in the first 5 years of life can have long-term consequences in that they affect learning, school achievement, and peer relationships in later childhood (Campbell, 2002; Lavigne et al., 2001; Loeber & Farrington, 2000; Shaw, Lacourse, & Nagin, 2005). Not surprising, the Surgeon General's Conference on Children's Mental Health (U.S. Department of Health and Human Services [DHHS], 2000) identified fostering social and mental health, a critical component of children's learning, general health, and well-being, as a national priority.

Preventive mental health interventions delivered in the first 5 years of life, which have been shown to reduce the risk of poor child outcomes, have yet to find a home in mental health service systems. This is

partially because of the failure of mental health services to adequately reach children in need, requirements in most states for children to have a mental health diagnosis to receive mental health benefits, and stigma related to mental health issues and diagnosis (Hinshaw, 2005; Spencer, Kohn, & Woods, 2002). In addition, most interventions targeting parents of young children were not specifically designed to address the needs of low-income or ethnic minority families, two growing segments of the U.S. population (Coard, Wallace, Stevenson, & Brotman, 2004; Forehand & Kotchick, 1996; Gorman & Balter, 1997). Families in poverty are among those facing the greatest challenges raising young children but the least likely to access mental health care.

The purposes of this article are (a) to present the case for providing health promotion and preventive interventions to low-income families with young children as standard practice in early childhood centers and (b) to describe the characteristics and effectiveness of the Chicago Parent Program (CPP) for promoting mental health in young children. Current estimates show that approximately 45% of preschool children from low-income families in the United States are enrolled in early childhood programs including day care, Head Start, prekindergarten, and nursery school (Lopez & de Cos, 2004). The largest portion of children enrolled in these centers are primarily of African American and Latino descent (Hamm, 2006), groups already underserved in the mental health system (DHHS, 1999). Examples of one strategy for incorporating mental health promotion services in child care centers using the CPP will be described to demonstrate feasibility and utility of this prevention and health promotion model. The CPP is an evidence-based parenting intervention for promoting mental health in young children, designed in collaboration with low-income, ethnic minority parents in Chicago.

Behavior Problems in Preschool Children

Manuel is a 3-year-old boy attending day care. He is the youngest of five children living in an immigrant Latino family struggling to make financial ends meet. Manuel's mother has many concerns about her son's behavior at home and in day care. Both she and his teacher agree that he has difficulty following directions, staying on task, listening, and controlling his temper tantrums when faced with frustration. Like many of the children attending this day care center, this is Manuel's first school experience, but he seems to be having more difficulty adjusting to the routines and rules than the other children. Manuel

has already become known as a "problem" in the classroom. Manuel's mother shares the teacher's concern and cares deeply about her son's well-being. However, she does not know what to do to help him. Indeed, she is having similar problems with her other children and has been criticized by her partner and extended family for not being a stronger disciplinarian. Other family members are now disciplining the children, creating conflict and inconsistencies in how misbehavior is being handled at home.

No single factor places young children at elevated risk for behavior problems. Rather, an accumulation and interaction of factors appears to influence children's mental health (Gorman-Smith, 2003; Sameroff et al., 2004; Youngstrom et al., 2003). Manuel, for example, is responding to a range of challenges including inconsistent discipline from adults, a stressful home environment, family conflict, and a new school experience. Biological and developmental factors related to emotional and behavioral regulation may also be affecting Manuel's ability to regulate frustration and novel experiences. These factors make parenting far more difficult for Manuel's mother.

There are several potentially protective factors that favor Manuel, including his youth, a mother who is very concerned about his behavior, invested family members, and his mother's desire to work with her son's teacher toward the common goal of improving his behavior. The cultural value of *familismo* (strong identification and attachment to family; Santiago-Rivera, 2003) among Latinos and strong religious and kinship bonds among African Americans (Hill, 1993) can also act as protective factors for families of color. It is important that health promotion and preventive interventions capitalize on these types of strengths and protective factors so that as parents acquire new information, they feel they are building on skills they value. This contributes to greater parenting confidence and positive outcomes in children (Powell, Dunlap, & Fox, 2006). Now is a critical time to support Manuel's mother's efforts before Manuel's behavior becomes more challenging and difficult to change and his mother's confidence becomes so shaken that she avoids setting limits on his behavior and collaborating with his teachers.

Research shows that up to 36% of low-income preschool children exhibit significant behavior problems (Anthony, Anthony, Morrel, & Acosta, 2005; Gross, Sambrook, & Fogg, 1999; Qi & Kaiser, 2003). Behavior problems not only are annoying to parents and teachers, they can have significant implications for low-income parents who rely on child care for

work. For example, expulsion rates for behavior problems from early childhood programs are up to 34 times greater than expulsion rates for children in elementary and high school (Gilliam, 2005). When preschoolers are expelled from early childhood programs, parents may be left without child care, leading to difficulties finding or maintaining employment. Research also shows that behavior problems in the first 5 years of life are associated with more academic and interpersonal problems in elementary school (Campbell, 2002; Keane & Calkins, 2004; Scaramella & Leve, 2004; Shaw et al., 2005).

These are costly problems. A recent study conducted by Foster and Jones (2005) tracked public expenditures for more than 1,000 kindergarten children with high rates of behavior problems, including costs of medications, mental health care, juvenile justice involvement, grade retention, and special education. The average cost per year for a child with elevated behavior problems was \$3,400. For a child whose behavior problems were severe enough to meet psychiatric criteria for conduct disorder, annual cost was more than \$8,700 per child. Averaged during the course of middle school and high school, the public cost of a child with behavior problems was \$23,996, whereas the cost of a child with conduct disorder was more than \$61,000.

Given the high price of childhood behavior problems, politicians, researchers, and economists now agree on the need for cost-effective preventive interventions in early childhood. As noted by James Heckman, Nobel laureate in economics, "the returns to human capital investment are greatest for the young for two reasons: (a) skill begets skill and (b) younger persons have a longer horizon over which to recoup the fruits of their investments" (Heckman, 2002, p. 5). The challenge now is to identify mental health prevention programs that are truly effective (based on rigorous evaluation) across diverse racial, ethnic, and income groups and establish cost-effective ways to deliver these programs to families in need.

Interventions Addressing Mental Health Promotion in Early Childhood Programs

The fundamental mission of early childhood programs is to provide safe surrogate care to children in ways that support their growth and development. Some programs, such as Head Start, have additional goals related to promoting children's academic and social skills and increasing parent involvement in their children's development. However, Head Start has historically struggled with whether to include

mental health services, in part because of the stigma associated with these services (Yoshikawa & Zigler, 2000). There is also insufficient funding from alternative sources for preventive interventions to support mental health in at-risk populations (Knitzer, 2007). As a result, many Head Start children are not receiving mental health services. In a study of mental health service use among Head Start parents, Razzino, New, Lewin, and Joseph (2004) found that only 21% of families needing mental health services were receiving them.

A number of recent efforts to provide mental health services in early childhood programs have been described in the literature. Some interventions focus on providing comprehensive educational programs and consultation for child care staff to enhance their work with children and families (Beeber et al., 2007; Chazan-Cohen, Stark, Mann, & Fitzgerald, 2007; McCallister & Thomas, 2007). Others have directly targeted parents for the purposes of improving parenting skills and decreasing child behavior problems.

Community-based parenting programs have been shown to improve parenting skills and decrease child behavior problems without stigmatizing young children and their families (Conduct Problems Prevention Group, 1999; Dumas, Prinz, Smith, & Laughlin, 1999; Gottfredson et al., 2006). This is because parenting programs are open to all parents, and they tend to focus on parenting knowledge and skills rather than parenting deficits. The advantages of using parenting programs in early childhood centers to promote young children's mental health are that these programs (a) serve a large number of young children from low-income families who might not otherwise receive mental health services; (b) focus on parents' strengths and skill-building rather than parenting deficits; (c) can be offered to all parents in need, not just families identified as at risk by child care staff, thereby avoiding the stigma associated with mental health services; (d) address behavioral symptoms and parent-child interactions associated with mental health problems of childhood; and (e) provide these services in a community-based agency already known and trusted by the families they serve.

A number of parenting programs have been shown to improve parenting outcomes, among them the Triple P-Positive Parenting Program (Sanders, Markie-Dadds, Tully, & Bor, 2000; Sanders, Markie-Dadds, & Turner, 2003), the Incredible Years Program (Webster-Stratton & Reid, 2003), and Parent-Child Interaction Therapy (PCIT; Eyberg et al., 2001), all

of which have been rigorously tested with disordered and at-risk populations (for more information regarding these programs, see Briesmeister & Schaefer, 2007). However, none of these programs was specifically designed for ethnic minority parents from low-income neighborhoods.

THE CHICAGO PARENT PROGRAM

Program Description

The Chicago Parent Program (CPP) is a 12-session, group-based parenting program created in collaboration with an advisory group of African American and Latino parents from economically diverse neighborhoods in Chicago (see Gross, Garvey, Julion, & Fogg, 2007, for a fuller description of the development of the CPP). Most parenting programs were originally designed for non-Hispanic White, middle-class parents and then later applied to other populations (Coard et al., 2004; Forehand & Kotchick, 1996; Gorman & Balter, 1997). Some of these programs relied on parents' reading skills or applied strategies that were congruent with White, middle-class values (Forehand & Kotchick, 1996; Martinez & Eddy, 2005). As a result, parents from other racial, ethnic, and income groups had difficulty using these programs or understanding their relevance (Forehand & Kotchick, 1996; Lundahl, Risser, & Lovejoy, 2006). The purpose of the CPP advisory group was to ensure that the program would be culturally and contextually relevant for ethnic minority and low-income parents raising children in urban communities.

The CPP uses more than 150 videotaped vignettes of parent and child models to demonstrate a range of parenting principles supported by research. These vignettes are shown to parents in groups led by trained group leaders who facilitate discussion related to how parents in the vignettes handled the modeled situation. A group-leader manual describes the important points in each vignette, lists questions for group leaders to focus the parent discussions, and includes weekly handouts and homework assignments standardizes each session. The CPP vignettes are used to stimulate discussion and problem solving rather than teach correct ways of interacting with children. The goal is for parents to tailor program principles to their parenting goals and values and to share ideas with each other in the group as to how they might apply the principles to their particular situation. Homework is assigned weekly to help parents practice and apply what they have learned with their children.

Two-hour parent-group sessions are conducted once a week for 11 consecutive weeks at the child's

TABLE 1. Weekly Chicago Parent Program Session Topics

Unit 1: The value of your attention (4 sessions)
Child-centered time
Family routines and traditions
Using praise and encouragement
Using rewards for challenging behaviors
Unit 2: Using your authority wisely (4 sessions)
Say what you mean and mean what you say
Threats and consequences
Using ignore and distract
Using time-outs
Unit 3: Managing your stress (2 sessions)
Reducing your stress
Problem solving
Unit 4: Sticking with the program (2 sessions)
Putting it all together
Booster session (2 months later)

day care center on weekday evenings (see Table 1). Free child care and dinner are provided at each session to reduce barriers to attendance. At the 11th session, parents and group leaders schedule a booster session to be held about 2 months later. The goal of the booster session is to discuss challenges parents have faced using the program without the ongoing support of the parent group and to review program principles.

Respect, tolerance, and diversity of opinion are important components of the CPP and essential if prevention and health promotion programs are to be effective in community settings serving low-income and ethnic minority families. A strength of the CPP is the use of a collaborative model for working with parents in the groups. This model emphasizes group leaders' working in partnership with parents by supporting them as the experts about their children and helping them tailor program principles to their individual needs, values, and child-rearing goals (Webster-Stratton, 1998). Families often mistrust experts who present them with "ideal" parenting strategies (often based on White, middle-class values) while dismissing, downplaying, or criticizing their current practices. Parents who participate in the CPP are offered a range of parenting strategies and encouraged to select and modify those they believe will work best for them and their children.

On the recommendation of Manuel's teacher, his mother decided to attend the CPP, a parenting group offered at her child's day care center. At the first session, she learned from the other parents that she was not alone; other parents in the group had the same problems she was having. This was an epiphany.

Feeling blamed by her family for her son's poor behavior, she had concluded that she was the only parent facing this problem. Manuel's mother quickly found the support she needed from this group. Each week, the parents in the group watched and discussed vignettes of parents and children engaging in situations that were all too familiar to her: tantrums at home and in public, trying to get compliance at home, getting children to bed at night, getting ready for school in the morning, and managing misbehavior. She watched parents in these vignettes handle each situation, sometimes well and sometimes not so well. The group discussed each vignette and what strategies appeared most effective. She also learned how her stress affected her child's behavior and how to use problem-solving skills at home with her partner and family to reduce conflict. Manuel's mother started using more praise with her son when he complied with her wishes, incorporated more routines in his day, and followed through more consistently on the limits she set. She also worked with his teacher on developing a reward program for good behavior. She and her son's teacher established a positive working relationship, and over time, both noticed improved behavior at home and at school. Finally, Manuel's mother brought home the written summaries of important points she received from each parent group so other family members could read what she was learning and understand how she was now learning to handle her son's behavior.

Effectiveness of the Chicago Parent Program

Manuel's story is important but anecdotal. Parenting programs need to be rigorously tested in randomized clinical trials to demonstrate their effectiveness for many children. Two studies have been conducted showing the effectiveness of the CPP for reducing behavior problems in young children (Gross, 2007; Gross et al., 2007). Both studies, which were approved by the institutional human-subjects review board, involved a sample of more than 250 low-income families of 2-year-old to 4-year-old children in Chicago.

The first study examined the effectiveness of the CPP for reducing behavior problems in day care classrooms (Gross et al., 2007). Day care teachers were asked to complete the Caregiver-Teacher Report Form, (C-TRF), for study children ages 1½ to 5, in their classrooms (Achenbach & Rescorla, 2000) at preintervention and again at postintervention. The C-TRF is a standardized checklist of child behavior that includes two scales. The Externalizing Scale assesses the degree to which the child is aggressive and inattentive in the classroom. The

Internalizing Scale measures the extent to which the child appears anxious, depressed, and withdrawn in the classroom. Both scales have defined cutoff scores for screening children with clinically significant behavioral problems. To evaluate the effect of the CPP on classroom behavior problems, we examined intervention-group and control-group children with scores exceeding these cutpoints at baseline and how many of those children improved by having their scores fall within the normal range at postintervention.

We found significant differences in improvement rates by experimental condition. Half of the intervention-group children with baseline externalizing scores above the cutpoint had scores in the normal range at postintervention, compared to 37.5% of the children in the control group. However, greater improvements were found for children with high scores on the Internalizing Scale; 85.7% of children in the intervention group showed significant improvements, compared to 28.5% of the control-group children. Improvements rates were unrelated to the parent's race, ethnicity, or family income or the child's gender. These results suggest that the CPP leads to improved child behavior in the day care classroom, supporting the observation made by Manuel's teacher.

The second study examined the long-term effect of the CPP on 253 parents and their 2-year-old to 4-year-old children up to 1 year after participating in the CPP (Gross, 2007). The program was offered in their children's day care center; all of the day care centers served low-income, ethnic minority families. Most families in the study were African American (58.9%) or Latino (32.8%). Participating day care centers were matched and randomly assigned to intervention and waiting-list control conditions. Observation and parent-report data were obtained at baseline, postintervention, and 6-month and 1-year follow-up intervals. Compared to the control group, parents who participated in at least half of the CPP sessions reported significantly greater improvements in parenting self-efficacy, used more positive and consistent discipline strategies, and used more positive parenting strategies during parent-child interactions. At 1 year postintervention, children whose parents participated in at least half of the CPP group sessions had greater reductions in behavior problems. These results are consistent with Manuel's mother's observation that her child's behavior had noticeably improved at home and her growing confidence in using the knowledge she was gaining from the parent groups.

An important finding from the second study was the role of parent participation in the intervention. Intervention effectiveness was far stronger when parents attended at least half of the CPP sessions. This result suggests that attendance at one or two parent group sessions is not sufficient to make lasting change in parenting and child behavior. Based on this finding, our current research focuses on increasing parent participation in the CPP intervention by discounting child care costs to low-income families who attend the parent group sessions. We will be evaluating cost, participation rates, and effect-size improvements in parent and child outcomes. These data will be used to inform state health policies regarding the cost-effectiveness of incorporating mental health promotion and prevention interventions in early childhood programs.

Manuel is going to kindergarten in the fall. His teacher reports that he is far more cooperative and has several friends he plays with regularly at day care. Manuel's mother says that he is also much better at home, a change she attributes to being calmer when she's with him, setting firmer and more consistent limits, and using more routines at home. However, the biggest change she has seen since ending the parent program is the improvement in her older son's behavior. He, too, is responding to the calmer but more consistent discipline strategies she originally used with Manuel. These changes have truly affected her confidence and willingness to follow through in disciplining her children even when other adults in the family question her techniques. To help them understand, she has been leaving copies of the CPP program handouts out for others to read. When Manuel's mother attended the booster session, she asked the group leader about the availability of couples counseling in the community. Several weeks later, both she and her partner began seeing a counselor to work on their relationship.

CONCLUSION

Implications for Practice, Education, and Policy

Armed with the knowledge that early intervention and attention to the parent-child relationship are important factors for the mental health and development of children, psychiatric nurses play an important role in developing and implementing parent programs in existing community settings. Currently, psychiatric nursing roles are predominantly focused on treating mental health problems that have already become firmly entrenched. In this

article, we have argued that psychiatric nurses could do far more by focusing interventions during the preschool years to prevent problems that lead to poor peer and family relationships and diminished school performance. This change in practice would require a shift in mental health care policy and funding from an emphasis on treatment to one on prevention. Potential roles for psychiatric nurses include provision of consultation and support to child care staff and working directly with children and families in these settings. Psychiatric nurses and advanced-practice nurses are positioned to take an active role in the dissemination and implementation of parent intervention and prevention programs in community settings. As evidence is emerging of the cost and clinical effectiveness of parenting interventions in the first 5 years of life, nurses can be in the forefront of implementation.

Patzel, Ellinger, and Hamera (2007) address the quality and availability of appropriate clinical sites as a challenge for nursing programs. Early childhood centers are an important but underused setting for student placement. Early childhood centers, particularly those in low-income neighborhoods, could provide an excellent opportunity for students to interact with parents and children experiencing environmental and perhaps biological risk factors for mental health problems. These centers are ideal placements for both undergraduate and graduate students for applying community-based preventive mental health and treatment strategies with children, families, and parent groups. Opportunities for interdisciplinary work are built into these settings, as early childhood centers employ professionals from other disciplines, among which are early childhood specialists, teachers, and social workers.

Most children growing up in low-income neighborhoods fare well despite challenging circumstances (Roehlkepartain, Mannes, Scales, Lewis, & Bolstrom, 2004); nonetheless, Manuel's struggles at home and at preschool are not unusual. The goal of parenting interventions such as the CPP is to build on parents' strengths, promote greater parenting skill and confidence, improve communication, and, ultimately, reduce mental health problems in young children. Like the experience of Manuel's mother, effective mental health interventions help parents feel good about themselves while teaching them new skills that support their children's well-being. Given the size of the populations they serve, early childhood programs such as Head Start are cost-effective venues for disseminating parenting programs that promote young children's mental health. Such

initiatives increase the odds that every child will have a healthy start in life.

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