Chapter 2
Family Engagement in Mental Health Treatment for Young Children

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Introduction

Mental health is a key determinant of individual development and well-being over the life course (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). The foundation for lifelong mental health is laid in early childhood, when young children's experiences with parents, family, and the broader environment have considerable influence on young children's rapidly developing brain (National Scientific Council on the Developing Child, 2007). Indeed, a strong and growing body of research demonstrates that "…the origins of disease are often found among developmental and biological disruptions occurring during the early years of life" (Shonkoff et al., 2009, p. 2252). Disturbances in children's relationships with their parents and other primary caregivers, such as child abuse and neglect and parental mental illness, have particular salience to early childhood mental health. Thus, engaging family members and other important adults in early identification and treatment of social, emotional, and behavioral challenges is essential to promoting positive mental health outcomes for children over the lifespan (Haine-Schlagel & Walsh, 2015; Ingolsby, 2010).

Young children can and do have mental health difficulties that can become more severe disorders when left untreated. However, despite the fact that the majority of

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mental health disorders have their origins in childhood, children's mental health – especially young children's mental health – has often been overlooked. Perhaps this is due, in part, to pervasive myths that young children are "resilient" and relatively unaffected by trauma and adversity, or due to limited public awareness that mental health challenges can emerge very early in life. In fact, an estimated one in five children, age 6 or younger, has a diagnosable mental health disorder (Vasileva et al., 2021). In turn, young children are at elevated risk for developmental and behavioral challenges; compromised stress response and immune systems; difficulties learning; poor physical and psychological health; and increased need for services later in life (Shonkoff et al., 2009). Advances in neuroscience, epigenetics, and the behavioral sciences have elucidated the processes underlying these associations, including how early child-rearing environments influence the developing brain; how genes and environmental conditions interact to influence development; how epigenetic and metabolic processes affect children's response to adversity; and how young children's relationships with their caregivers influence these processes (Boyce et al., 2021).

The current chapter reviews extant research on family engagement in the treatment of early childhood mental health disorders using an ecological lens that recognizes the influence of parent-child relationships, family, and broader developmental contexts on the social and emotional well-being of preschool children (i.e., mental health). Specifically, this chapter focuses specifically on how early trauma influences parenting quality and family functioning, which in turn affect young children's mental health (Bronfenbrenner & Morris, 2006; Cicchetti & Valentino, 2006). We discuss the impact of mental health challenges on preschool-age children (3–6 years), their families, and on mental health providers, highlighting socioeconomic, racial, and ethnic inequities in early childhood mental health and related services. We describe promising, evidence-based treatments, and we identify central limitations of extant knowledge and offer recommendations for research, policy, and practice in early childhood mental health.

Early Childhood Mental Health

Early childhood mental health (ECMH), often referred to as infant and early childhood mental health (IECMH) to be inclusive of infants and toddlers, is more than the absence of psychological disorders. Rather, it represents the young child's developing social and emotional skills, including the ability to form healthy relationships with adults and peers, as well as to express and manage the full spectrum of human emotions (World Health Organization [WHO], 2022; Zero to Three, 2017, 2023). ECMH also represents the continuum of services, from promotion to prevention to treatment, which are needed to support young children's development, prevent mental health problems from emerging, and address social and emotional challenges before they become more serious disorders (Zero to Three, 2017, 2023).

A young child's risk for developing a mental or behavioral disorder depends in part on biological predispositions, but the environments in which children are embedded also exert a particularly strong influence (National Scientific Council on the Developing Child, 2004, 2023). For example, the quality of care children receive from their parents and other primary caregivers (i.e., biological, foster, and adoptive parents, foster and kinship caregivers, extended family, and others who care for the child on a regular basis) is one of the most salient factors influencing young children's mental health (National Academies of Science, Engineering, and Medicine, 2016). In the USA, common mental health disorders diagnosed in children ages 3 and older include depression, anxiety, and trauma/post-traumatic stress disorder (PTSD) (von Klitzing et al., 2015). Manifestations of ECMH challenges, including young children's level of distress, behavior, and overall adjustment, vary among children and families (WHO, 2022). Preschoolers' mental health also varies in relation to the nature of their experiences in the world, such as the type, severity, and chronicity of exposure to trauma (National Child Traumatic Stress Network [NCTSN], n.d.). In situations of extreme stress (e.g., separation from biological parents and placement into foster care or orphanages), young children may develop reactive attachment disorder (RAD), though the overall prevalence is low (one percent) (von Klitzing et al., 2015). Behaviors commonly observed during the preschool years that may indicate early trauma or another mental health condition include repeated reenactment of traumatic events or situations in play; avoidance of or extreme separation anxiety in absence of caregivers; compulsive behaviors (e.g., repeated handwashing or use of the same words or phrases); severe tantrums; withdrawal from or disinterest in social interactions; difficulties socializing with peers; highly aggressive or impulsive behavior; limited language development or communication; regression after achievement of developmental milestones (e.g., using the toilet, sleeping independently); and high levels of fear and anxiety (Zero to Three, 2017).

There is widespread consensus that the etiology of early mental health disorders is multidetermined – the product of a combination of biological and environmental forces (Swanson & Wadhwa, 2008). A young child's risk for developing a mental or behavioral disorder depends in part on biological predispositions, but the environments in which children are embedded exert a particularly strong influence (National Scientific Council on the Developing Child, 2004, 2023). The early years are a sensitive period in which prolonged periods of severe stress, unmitigated by positive experiences, can result in harmful impacts on early brain development (Birnie & Baram, 2022). Deficits related to ECMH problems can persist into young adulthood, with a trajectory of continuing educational, mental, and physical problems (Schlack et al., 2021). Treatment for mental health problems during this formative stage has been found to ameliorate many negative developmental outcomes and ensure more positive mental health for future generations (Kieling et al., 2011).

Inequities in Early Childhood Mental Health

Rates of ECMH disorders are especially high among historically impoverished and marginalized families (Jones et al., 2019). Poverty is an especially pernicious risk factor for poor childhood mental health, with particularly high rates of ECMH disorders observed among young children residing in low-income families (Zach et al., 2016). Children living in poverty are two to three times more likely to have a diagnosable mental health condition than those who live in financially secure families (Reiss, 2013).

Conversely, residing in positive caregiving environments has been found to reduce behavioral, social, and emotional problems, and increase family resilience to adversity and trauma (Council on the Developing Child, 2023). Racial and ethnic disparities in ECMH impede child and family well-being (Annie E. Casey Foundation, 2022). For example, children who are Native American, Black, and Latinx have higher rates of mental health challenges compared to their White peers (Annie E. Casey Foundation, 2022; Zach et al., 2016). These minoritized populations also have less access to high-quality treatment (across settings) due to factors such as structural racism, limited service availability, lack of insurance coverage, stigma, incongruence between the treatment approach and family culture, and language barriers (Rodgers et al., 2022).

The COVID-19 pandemic exacerbated mental health problems among young children and their families, as well as related racial and ethnic disparities in mental health and access to related services and supports (Hawks, 2023). The number of children ages 3 and older with anxiety and/or depression rose from approximately 5.8 to 7.3 million during the pandemic, with mental health challenges increasing more among children of color than White children (Annie E. Casey Foundation, 2022). Racial disparities in ECMH services also grew during the transition to telehealth and decrease in urban-based mental health treatment (Williams et al., 2023). Improving equitable access to treatment among families of color is critical to promoting ECMH, including working with families to increase their financial stability and overcome barriers to treatment, such as historical and structural racism and related distrust in public services, stigma, lack of child care and transportation, and limited time off from work (Williams et al., 2008). In addition, mental health providers and programs can promote family engagement in treatment by offering services in places that children already spend time (e.g., home, early childhood education program, school, primary care) and at times they are available (Haine-Schlagel & Walsh, 2015).

An Ecological Approach

There has been increasing consensus among experts in the field of ECMH that an ecological approach is most appropriate for understanding risk and resilience in the lives of young children (Cicchetti & Valentino, 2006). An ecological approach

is rooted in the notion that environments influence human development (Bronfenbrenner & Morris, 2006). From this perspective, the child is embedded in multiple contexts in varying proximity to the child, such as the family, early childhood education, schools, communities, and sociopolitical contexts (e.g., federal, state, and local policy, climate change, racism, and other forms of oppression), with risk and protective factors interacting at every level over time. Individual characteristics of children (e.g., biology, age, developmental stage) and parents/caregivers (e.g., mental health, prior exposure to trauma), as well as environmental stressors (e.g., unsafe or resource-poor neighborhoods, inadequate or overcrowded housing) and supports (e.g., safe housing, access to mental health care, high-quality child care), all play an important role in ECMH, but the caregiving environment has long been understood to be the most proximal and consequential for young children's mental health and development (Bronfenbrenner & Morris, 2006; National Scientific Council on the Developing Child, 2004).

A Trauma-Informed Approach

A trauma-informed approach to engaging families in young children's mental health treatment is also central to successful treatment given that nearly half of children in the USA – approximately 34 million – experience at least one potentially traumatic experience in early childhood (Bethell et al., 2017). Young children are exposed to a wide range of traumatic events and conditions, such as child abuse and neglect, intimate partner violence, parental mental illness and substance misuse, separation from or loss of a caregiver, unintentional injuries, discrimination, community violence, and natural disasters. A trauma-informed approach aims to "build on consumer and family engagement, empowerment, and collaboration" (SAMHSA, 2014, p. 14), and thus, engaging families in treatment is a cornerstone of successful care. Ames and Loebach (2023) emphasize that trauma-focused treatment and other ECMHC approaches should be applied systemically, at every level of a program, to reap maximum intervention benefits.

Engaging Families in Identifying and Treating Early Childhood Mental Health Challenges

One key factor in effective mental health services for young children is utilizing a two-generation approach that attends to the child, the parents/caregivers, and the caregiver-child relationship (Lieberman & Van Horn, 2008). All children develop bonds, or attachments, with their parents or other caregivers (Ainsworth & Bell, 1970; Bowlby, 1978). Thus, adults are "essential resources for children in managing emotional arousal, coping, and managing behavior" (National Academies of

Sciences, Engineering, and Medicine [NASEM], 2016). On the other hand, limited family engagement in treatment for young children poses serious problems for families and programs alike, such as the reduction of treatment effectiveness and families dropping out of treatment (Haine-Schlagel et al., 2022).

The consequences of poor family engagement in treatment are significant. Treatment may be less effective, and certain groups of families may receive poor-quality treatment or no treatment at all, including those with severe mental health conditions and living in poverty, and historically marginalized families may not receive adequate treatment. Further, mental health agencies incur considerable costs associated with no-shows and cancelled appointments (Kazdin 1996). Families living in poverty, minoritized families (e.g., families of color, LGTBQ families), and families struggling with severe child or adult mental health conditions tend to have particularly high rates of dropout, which warrants further attention from researchers, policymakers, and practitioners related to optimal methods of engaging families facing such adversity in their lives (Snell-Johns et al., 2004).

Family engagement has been conceptualized in myriad ways, but a contemporary view of family engagement is that it extends beyond parent participation in services or compliance with treatment (Staudt, 2007a, b). Staudt (2007a, b) theorized that both behavioral and attitudinal aspects of engagement are relevant to outcomes, and introduced a five-component, empirically based, theoretical framework for engagement of caregivers in treatment for at-risk children:

1. *Treatment relevance and acceptability*: parents need to feel that treatment is justified and palatable.
2. *Cognitions and beliefs about treatment*: parents must view the provider as caring, authentic; and concerned for their well-being.
3. *Daily stressors*: difficulties of daily life are manageable.
4. *External barriers to treatment*: obstacles to treatment access and retention, such as lack of health insurance, stigma, and other obstacles, must be addressed.
5. *Cognitions and beliefs about treatment*: negative perceptions of help-seeking and mental health treatment interfere with engagement and warrant attention from providers and programs.

Staudt's holistic framework serves as the working definition of family engagement throughout this chapter.

Engaging Families in Treatment

Families are integral to early intervention in general and to services that address the mental health needs of young children in particular (Lieberman et al., 2015). Family members typically have extensive knowledge about their child; the quality of parent-child relationships; family functioning; individual family members' strengths and needs; culture (e.g., values, beliefs, and preferences regarding mental health, and parenting); and the social and physical environments in which they live – all

essential information for treatment planning (Bartlett, 2020a, b; SAMHSA, 2014). In addition, parents work collaboratively with mental health providers to provide social, emotional, and concrete supports to the child outside of therapy sessions (Lucksted et al., 2012). Strong family engagement also improves transmission of knowledge to parents and enhances engagement of parents in interventions to improve child functioning (Smith et al., 2020). Perhaps most importantly, young children's mental health is inextricably tied to the well-being of their parents and other primary caregivers, and caregiver-child relationships are the primary mechanism for improving young children's mental health (Lieberman et al., 2015).

Effective strategies for enhancing family engagement included outreach to families; telehealth and digital health (i.e., technology to facilitate communication between providers and families, offer psychoeducation coordination of referrals and follow-up, and deliver clinical services); and integrated care approaches, with the strongest evidence found for outreach to families and integrated care. Including extended family (e.g., grandparents, foster, kinship, and adoptive parents) and other important adults (e.g., a friend who provides child care) as defined by the family in early identification (i.e., screening) and treatment of ECMH challenges can enhance information gathering and mobilize support for the child, which may be especially important for families who rely most on natural supports in their own families and communities (e.g., Falicov, 2007). Understanding, expressing curiosity about, and being responsive to diverse family configurations, characteristics, beliefs, and preferences are especially important strategies for engaging the diversity of families who would benefit from ECMH treatment, particularly when the provider and family are from different cultural backgrounds (Conroy et al., 2021).

Engaging Families in Early Identification

Early identification of symptoms and disorders is a crucial element of promotion, prevention, and treatment of mental health problems that emerge among young children. Accordingly, the central aim of early childhood mental health screening and diagnosis is to prevent further suffering and reduce the chances that children develop more severe disorders later in life by identifying and treating problems early (Bartlett, 2020a, b; Cohen & Andujar, 2021).

Engaging families in the process of screening and diagnosis is essential to effective identification of mental health symptoms and conditions, particularly given that parents are experts on their own children and have the most power to improve their mental health. Thus, screening should take place in the context of a partnership with parents and other caregivers. Not surprisingly, parent report is often used to assess mental health symptoms in young children. And while parental report has sometimes been characterized as less subjective and informative than the "gold standard" of assessing parent-child interactions, parents can supply information on their children that others cannot, and they have been found to be especially attuned to the

severity of the child's symptoms and to conditions that are challenging to identify in early childhood, such as depression (McGinnis et al., 2022).

To screen children effectively, the first author and colleagues (Bartlett, 2020a, b) recommend a comprehensive, holistic approach to screening that includes the use of a validated, trauma-informed developmentally appropriate, culturally responsive mental health screening tool; assessment of parent child relationships, parent well-being, family functioning, and social determinants of health; as well as identification of child and family strengths. For additional information on early childhood screening, see Halle and Darling-Churchill (2016) for a review of measures to assess young children's social and emotional measures and Bartlett (2020a, b) for a review of screening and assessment of early trauma and adversity.

Following screening and any additional assessment needed, mental health and developmental disorders during early childhood can be classified by licensed mental health providers using the DC:0–5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Version 2.0 (Zero to Three, 2016). The DC:0–5 drew on empirical research and clinical practice to identify childhood disorders that are not otherwise covered in other diagnostic manuals, such as the Diagnostic and Statistical Manual, Version 5 (DSM-5-TR; American Psychological Association, 2022) or International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM; WHO, 1999), and also provide codes for medical claims reporting. The DC:0–5 facilitates understanding of the young child's social and emotional development, as well as experience in the context of family, community, and culture. The DSM and ICD focus on disorders in older children and adults and do not address parent-child relationships; the DC:0–5 is a nosology of infant and early childhood disorders that integrates relationships into diagnosis (e.g., rating of the primary caregiving relationship(s) and caregiving environment). The next step following early identification of emotional, behavioral, or relational challenges is to support families in obtaining access to effective treatment.

Evidence-Based Early Childhood Mental Health Treatments

Child-Parent Psychotherapy

Child-parent psychotherapy (CPP; Lieberman et al., 2015) is a therapeutic treatment for children from birth to 5 years who have experienced trauma and/or have developed mental health, attachment, and/or behavioral problems and disorders. Based on attachment, psychodynamic, trauma, social learning, cognitive-behavioral, and developmental theories, all sessions include the child and parent or primary caregiver. The primary aim of CPP is to repair and strengthen the relationship between a child and caregiver to support the child's cognitive, behavioral, and social functioning. Weekly sessions are provided by master's or doctoral-level therapists, who facilitate weekly hour-long sessions with parents/caregivers and their young

child for a period of 1 year. Caregiver participation is a required element of CPP, and providers are encouraged to tailor their engagement strategies to each family. Evidence from rigorous research with families from diverse backgrounds has shown that CPP improves child behavior (e.g., decreasing child post-traumatic stress) and reduces parental stress and improves their emotional functioning (e.g., Ghosh Ippen et al., 2011).

Parent-Child Interaction Therapy

Parent-child interaction therapy (PCIT; Querido et al., 2002) is an empirically supported intervention, grounded in attachment theory, social learning theory, behavior modification, and system theory, meant to treat behavior challenges in children. During 14–25 weekly sessions, master's level clinicians observe the parent and child through a one-way mirror and provide guidance through a microphone in the parent's ear. Eyberg and Robinson (1982) proposed that identification of interaction patterns in the family and promotion of positive interactions positively influenced young child, parent, and family functioning. Parents and primary caretakers learn child-directed interactions, and are asked to allow the child to direct the play, and parents describe the play, reflect the child's statements, and use praise appropriate behavior. There is also parent-directed interaction, such as giving clear directions for preferred behaviors (not using questions such as "Would you give me the doll now?") and initiating time-outs for inappropriate behaviors that cannot be ignored. Results of a meta-analysis (23 studies) showed that children were more likely to follow instructions, and parental stress decreased after participating in PCIT; this occurred irrespective of length of sessions and type of child behavior problems (Thomas et al., 2017). PCIT also has been found to reduce children's externalizing behavioral problems (e.g., aggression, hyperactivity), with stronger impacts found among families who completed the full course of treatment compared to those who terminated after the first of two phases (Thomas et al., 2017).

Trauma-Focused Cognitive-Behavioral Therapy

Trauma-focused cognitive-behavioral therapy (TF-CBT; Cohen et al., 2018) is an evidence-based treatment model for children, ages 3–18 years, who have experienced and remember at least one form of trauma. The master's or doctoral-level mental health provider facilitates 12–25 sessions, spending about 30 minutes with the child and 30 minutes with the parent, adding conjoint child-parent sessions later in the treatment process to support children-parent communication. This structure was chosen over family sessions based on the belief that child trauma impacts both parents and children and that each derives benefits from individually processing their trauma responses. One of the central principles of TF-CBT is the importance of engaging parents or other primary caregivers in treatment (Cohen & Mannarino, 2015).

A review of two meta-analyses on ten randomized control trials of TF-CBT by de Arellano et al. (2014) found positive outcomes and, notably, reductions in post-traumatic stress disorder (PTSD).

Triple P

The Triple P Positive Parenting Program, is a multilevel, prevention-focused approach to working with families whose children, ages birth to 16 years, have severe behavioral, emotional, and developmental problems by increasing parental knowledge, skills, and confidence (Sanders, 1999). Triple P implements five levels of care with increasing intensity of services: universal prevention; selective and primary care for parents who wish to address specific problems; standard Triple P for children with severe behavior problems; and enhanced Triple P for children with behavior problems and families exhibiting dysfunction. The Triple P program has been studied extensively and found to be effective over time with a range of problems, ages, and settings, including efficacy in preventing child abuse and neglect (Sanders & Mazzucchelli, 2018; Sanders et al., 2022). Research on the enhanced Triple P's group parenting program for mothers with depression shows the program is related to decreases in maternal depression and decreases in children's social, emotional, and behavioral problems (Sanders et al., 2014).

Promising Early Childhood Mental Health Treatment Models

Attachment, Self-Regulation, and Competency (ARC) Model

The Attachment, Regulation, and Competency (ARC; Kinniburgh et al., 2005) Framework is a flexible, component-based intervention for children and youth ages 3–21 who experience complex trauma, as well as their caregiving systems (any and all adults who are primary caregivers for the child). The ARC Framework is an individual practitioner and organization-wide approach with a clinical model designed to treat the child based on the premise that secure attachments are critical for positive development (Kinniburgh et al., 2005). The caregiver learns to respond to consistent routines and establish a secure attachment, and the child learns to recognize, express, and moderate their emotions (Kinniburgh et al., 2005). The therapist and caregiver assist the child in processing traumatic experiences in a developmentally appropriate fashion. The therapist uses child-centered play to help the child work through traumatic experiences. Children who complete ARC treatment have shown reductions in PTSD symptoms and behavior problems in longitudinal studies (e.g., Bartlett et al., 2016).

Circle of Security

The Circle of Security Program is a program for parents of children ages 4 months through 6 years based on attachment theory and three decades of clinical practice (Hoffman et al., 2006). Circle of Security is a relationship-based early intervention program designed to enhance attachment security between parents and children. Parents or other caregivers explore their own attachment issues and also work to establish a secure attachment relationship with their young child. Parents meet in groups, watching videos with a trained facilitator to guide them through psychological issues that can cause them to make negative attributions about attachment behaviors of their child when their child is interacting with them (https://guidebook.eif.org.uk/programme/circle-of-security-parenting). There is a wealth of research and practice evidence, including a randomized clinical trial in Head Start, supporting this intervention (Cassidy et al., 2017; Huber et al., 2019).

Effective Black Parenting Program

The Effective Black Parenting Program (EBPP) is a parenting skill-building program specifically designed for parents of African American children, ages birth to 18 years. It has been identified as a promising intervention in child welfare (Title IV-E Prevention Services Clearinghouse, 2022). Parents select goals for their children from a menu of interventions designed for Black American parents, termed a "Pyramid of Success." Parents learn through discussion of videos showing different scenarios relevant to parenting young children. There typically are about 14 group sessions for groups of 15–30 parents, and trained instructors are from the same cultural group (https://www.hwcmn.org/EffectiveBlackParenting). Studies indicate that this intervention improves secure and positive attachments with young children, use of praise by parents, as well as reduces parental rejection of children and use punishment (hitting and spanking) (Leathers et al., 2011).

Other Services and Supports to Promote Early Childhood Mental Health

Infant and Early Childhood Mental Health Consultation

Infant and early childhood mental health consultation (IECMHC) is a service in which mental health providers partner with early childhood programs (e.g., early childhood education, Head Start, home visiting) to build their capacity to promote healthy social and emotional development among young children before they need more intensive intervention for mental health and behavioral problems (Center of Excellence for Infant and Early Childhood Mental Health Consultation, n.d.).

IECMHC is a preventative approach in which early childhood service providers gain the skills and knowledge they need to promote young children's social and emotional well-being through consultation with a mental health professional. Typically, the mental health consultant works with staff to problem-solve about children's challenging behaviors; observes child behavior and provider-child interactions; offers relevant training for staff and parents; collaborates with families; and supports the referral of children and their families to other services in the community, as needed (Cohen & Kaufmann, 2005). Consultants strive to be nonjudgmental and reflective and express curiosity about individual, family, and broader environmental influences on the psychological well-being of children and adults (Division for Early Childhood of the Council for Exceptional Children, 2017). IECMHC is associated with fewer child emotional and behavioral problems and improved social skills, increased staff self-efficacy, competence in managing children's challenging behaviors, sensitive and less punitive interactions with children, as well as reductions in providers' work-related stress (Silver et al., 2023). At the program level, IECMHC is associated with reductions in staff turnover and improved quality of care in early childhood education settings (Perry et al., 2010; Silver et al., 2023).

Home Visiting

Home visiting is a service strategy that connects young children (birth to age 5) and expectant and parenting adults with a service provider to promote maternal and child health; children's health development and school readiness; family economic self-sufficiency; and positive parent-child relationships, including preventing child abuse and neglect (Kleinman et al., 2023). The federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is the main source of funding for home visiting in the USA. The Health Resources and Services Administration (HRSA, 2023b) oversees MIECHV and currently awards $400,000 million or more annually to 56 states, territories, and nonprofit organizations. The Administration for Children and Families' Office of Early Childhood Development leads Tribal MIECHV and has provided $140 million to 36 tribal entities to date to implement high-quality, culturally grounded programs in American Indian and Alaska Native (AIAN) communities (ACF, n.d.). Both MIECHV programs require the development and coordination of comprehensive early childhood systems of care, including mental health (ACF, n.d.; HRSA, 2023a). MIECHV is not a mental health program (nor is home visiting), but most local programs require screening for maternal mental health issues and child health, mental health, and development, and three-quarters of programs screen for maternal substance abuse, intimate partner violence, and problematic parenting behaviors. However, home visitors report challenges engaging mothers with mental health challenges, and in these instances, additional professional development on addressing mental health may be especially important (Duggan et al., 2018). Nevertheless, rigorous evaluation of home visiting programs reveals positive impacts, including preventing child abuse and neglect; improving birth outcomes and children's school readiness; and higher maternal high school graduation

rates among racially diverse samples, which are empirically linked to positive mental health outcomes for children (National Conference of State Legislatures, 2022).

Integration of Early Childhood Mental Health into Primary Care

Offering mental health services in the context of primary care has advantages, such as the fact that families often go to pediatricians first to seek advice about concerns related to their children's social and emotional well-being; pediatricians follow families over time, and pediatric care is less stigmatized than mental health care (Hodgkinson et al., 2017). The field of pediatrics has increasingly turned attention to its role in supporting children's social and emotional health and through the promotion of safe, stable, and nurturing relationships (SSNRs) that can buffer children from adversity and support resilience in development (Garner & Yogman, 2021).

A family-centered pediatric medical home (FCPMH) is a mechanism for addressing young children's relational and mental health needs (Garner & Yogman, 2021). FCPMHs provide comprehensive, high-quality primary care, with a focus on partnering with families, mental health providers, early childhood professionals, community organizations, educational systems, and other key community resources within a single system of care (American Academy of Pediatrics, 2021). FCPMH is "a family-centered partnership within a community-based system that provides uninterrupted care with appropriate payment to support and sustain optimal health outcomes" (American Academy of Pediatrics, 2021).

One example of the FCPMH model is Zero to Three's Healthy Steps, which embeds a child development expert into primary care. Healthy Steps has eight core components: child developmental, socio-emotional, and behavioral screenings; screening for family needs; a child development support line; three consultation sessions with parents on child development and behavior; interdisciplinary team well-child visits; care coordination and system integration; positive parenting guidance and information; and early learning resources (Valado et al., 2019).

A national multi-site evaluation indicated the program had positive outcomes for children, families, and providers, including improved physician and caregiver satisfaction and continuity of care; better compliance with recommended well-child visits and vaccinations; and higher rates of developmental screening. There were also modest reductions in parents' use of severe physical discipline. Children were more likely to remain in the practice, and parents were more satisfied with care than control group counterparts (Valado et al., 2019).

Barriers to Family Engagement in Mental Health Treatment for Young Children

Some barriers to obtaining mental health treatment for young children pertain to the logistics of accessing and attending therapy sessions, such as a lack of health-care coverage, child care, transportation, time off from work, and geographically

accessible services (Garvey et al., 2006; Stevens et al., 2006). Another obstacle identified in the literature is a lack of alignment between a program/provider's approach and the family's beliefs, values, and preferences related to mental health, help-seeking, and parenting (Ingoldsby, 2010; Stevens et al., 2006). In addition, there are not nearly enough treatment providers to meet the current need nor who reflect the racial and ethnic backgrounds of those they serve (Buche et al., 2017).

A review of the research on family engagement in children's mental health treatment by Ingolsby (2010) found that providers were most successful engaging families when they communicated in-depth with the family about the treatment process, such as its potential benefits, realistic expectations for the treatment process and outcomes, and practical and psychological barriers to obtaining treatment for their child. When providers do not address such potential mismatches, families are more likely to drop out of treatment (Miller & Prinz, 2003). Successful strategies for engaging families also include tailoring treatment to each family's needs using a range of approaches engaging multiple family members, and integrating family engagement strategies throughout the program.

Systems of Care for Supporting the Mental Health of Young Children and Their Families

Families often interact with multiple services systems, such as mental health and substance use treatment; health care; early childhood education; housing and financial assistance programs; and others. Typically, service systems do not coordinate services for families with young children, who are burdened by different eligibility requirements, geographical locations, service providers, and organizational policies and practices. Conversely, embedding early childhood mental health treatment within comprehensive systems of care that connect families to the wide range of supports and services they need has been hypothesized to reduce barriers to access and improve child and family outcomes (Stroul et al., 2021). Common components of an early childhood system include interdependent policies, programs, services, and infrastructure among child- and family-serving systems, and the linkages among all elements (BUILD, 2023).

Several federal programs have sought to address service silos and provide comprehensive and coordinated systems of care, such as HRSA's Early Childhood Comprehensive Systems (ECCS) program. The program requires grantees to develop integrated maternal and early childhood systems of care (prenatally to age 3) that promote early developmental health and family well-being using a prevention lens and cross-system collaboration (HRSA, 2023b). More relevant to preschool-age children, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) to promote the social and emotional wellness of young children, birth to 8, by building infrastructure, improving coordination across child-serving systems, and increasing families' access to high-quality services

(SAMHSA, 2023). Grantees (states, tribes, and territories) seek to improve individual, family, and community outcomes by bringing together local child-serving organizations to implement five mental health prevention and promotion strategies: (1) screening and assessment in a variety of child-serving settings, (2) enhanced home visiting through increased focus on social and emotional well-being, (3) mental health consultation in early care and education programs, (4) family strengthening and parent skills training, and (5) integration of behavioral health into primary care settings, although the specific strategies change from year to year. This work is guided by a Young Child Wellness Council, a cross-sector advisory group that requires parent engagement. A cross-site evaluation by Goodson et al. (2014) found that LAUNCH providers in each of the program strategies had increased knowledge of children's socio-emotional development and appropriate service options for children with behavioral concerns, and they used mental health consultation more often; parents reported LAUNCH helped improve their parenting and their child's growth and development.

Caring for the Caregivers

Engaging families is an essential component of effective mental health treatment, but the work can be stressful for providers. Burnout among mental health providers is a common and ongoing phenomenon related to working with families who have experienced trauma (NCTSN, Secondary Traumatic Stress Committee, 2011). Through repeated exposure to children and families who have experienced trauma, mental health providers may develop post-traumatic stress symptoms and become overwhelmed by their clients' difficult experiences, leading to negative consequences for both their personal and professional functioning (Weiss-Dagan et al., 2022). The symptoms of secondary traumatic stress (STS), sometimes referred to as compassion fatigue, develop as professionals learn about the trauma of these families and continuously draw on their own empathy toward their clients (Figley, 2002). Providers may develop detached, negative attitudes toward treatment, leading them to turn that dissatisfaction toward themselves as they feel unhappy in their work (Key & Rider, 2018). Alternatively, providers may need to draw on their emotional memory to express the empathy they display to families. Emotional distress from exposure to firsthand experiences of child and family trauma can trigger their own experience of these emotions (e.g., concern, regret, empathy, post-traumatic stress) and lead to over-involvement in their clients' treatment (Morse et al., 2012). STS symptoms also affect the day-to-day mental state of the provider, leading to feelings of anxiety, depression, fear, withdrawal from personal or work activities, and intrusive thoughts and images (Ogińska-Bulik et al., 2021).

Research indicates that there are multiple protective factors that can promote the psychological well-being of mental health providers (Key & Rider, 2018), which programs and staff can employ to mitigate risk for STS. Self-care through social support is one powerful predictor of compassion satisfaction in mental health

professionals (Weiss-Dagan et al., 2015). For example, Killian (2008) found that when therapists felt connected to members of their community and could ask for help from their social network when needed, they reported lower levels of compassion fatigue and higher satisfaction with the client work they performed. Further, the Office of Head Start (OHS, 2021) recommends that programs collect and analyze data on staff wellness to better understand what supports are needed (OHS, 2021). Programs can also determine which positions have high turnover rates, and what resources they can allocate to reduce staff burnout and turnover and increase individual wellness. Programs can also implement strategies in the workplace to support self-care at the system level and show the value in providers' health and well-being. For example, utilizing online platforms for mindfulness and resilience workshops, as well as physical spaces purely for relaxation purposes (soft, calming music, dimmed lighting, etc.), can be restorative for providers' emotional needs (National Child Welfare Work Institute, 2021). When programs communicate with employees about their wellness needs, they can create a work environment built on mutual respect, trust, and collaboration, in turn leading to higher self-efficacy and feelings of support from their employer (OHS, 2021).

Clinician attitudes toward their organization are also related to their experience of burnout (Boyas et al., 2010). The more they feel connected to their employer through the provision of support systems and encouragement, the less emotional exhaustion and detachment they feel (Schmidt, 2007). Staff education about self-care practices, burnout, and STS, especially early on in their work with children and families, can prepare them for trauma exposure, equip them with skills to manage emotional exhaustion, and increase their emotional self-awareness (National Child Welfare Workforce Institute, 2021; OHS, 2021; Killian, 2008). Further, designating time for reflective supervision, where staff meet with their supervisors to discuss challenging cases and emotions that arise as they are supporting families, can be effective at improving care quality, staff retention, and family outcomes (West et al., 2022). When clinicians are empowered to address their own emotional and support needs and struggle less with traumatic stress at work, they better engage with the families and children they seek to help (Key & Rider, 2018; Weiss-Dagan et al., 2022).

Limitations of Current Knowledge

A "robust research agenda on cost-effectiveness, strategy coordination, and cultural challenges should be mounted and drawn upon to inform the next generation of strategies to promote the mental, emotional and behavioral health of children and youth" (Yoshikawa et al., 2012, p. 282). While the field of ECMH has expanded considerably in recent years, research is still needed to identify effective strategies for engaging families from different racial, ethnic, and socioeconomic backgrounds, as well as LGBTQ families and other marginalized groups who often encounter daunting barriers to accessing the services their child needs (Hodgkinson et al.,

2017). Because rigorous research is expensive, is time-consuming, and requires specific research expertise, and thus is not feasible for many smaller, community-developed, culturally grounded ECMH treatment model developers, support from federal, state, and local stakeholders is essential to identifying, testing, and scaling culturally grounded ECMH services, as well as identifying the contextual factors that influence its effectiveness (Goodkind et al., 2017; Lifsey et al., 2015). Increasing the evidence for early intervention to promote ECMH among children from low-income and minoritized backgrounds is particularly important given high levels of exposure to social risk factors associated with poor parental and child mental health; elevated rates of ECMH disorders among Black, Hispanic, and AIAN families compared to non-Hispanic White children; and the lack of access to high-quality, culturally grounded evidence-based treatment (Hodgkinson et al., 2017; Rodgers et al., 2022).

Extant studies suggest that motivational interviewing, family systems work, and support for coping with stress throughout treatment are strategies associated with improved engagement of parents and families, but the wide variation in how they are implemented warrants attention from researchers and practitioners to establish fidelity so they can be replicated and scaled successfully (Ingolsby, 2010). Research is also needed to determine the value-added of tools and frameworks designed to improve parent and family engagement across service sectors. For example, Facilitating Attuned Interaction (FAN; Gilkerson, n.d.) is an "add-on" tool that helps practitioners across disciplines to develop stronger, more respectful, and trusting relationships with families based on the understanding that attunement facilitates a sense of connection and being understood, creating openings for change. Studies of FAN have shown promising results for improving provider attunement and responsiveness to family needs, increasing parental agency, and enhancing collaboration between parents and providers to promote positive parenting (Spielberger et al., 2016). Another example is the Parent, Family, and Community Engagement (PFCE) Framework developed by the Office of Head Start's National Center on PFCE (US Department of Health and Human Services, 2018), which has never been tested empirically yet guides Head Start's family engagement efforts.

Finally, study of the ECMH workforce and evaluation of initiatives aimed at increasing the cadre of well-trained mental health providers in the USA who work across the promotion-prevention-treatment continuum will be vital to developing sufficient capacity to support the mental health and well-being of all families who would benefit from ECMH services (Bartlett & Stratford, 2021). Currently, the shortage of mental health providers, rising rates of mental illness, and scarcity of providers in rural and economically stressed areas are undermining families' ability to access treatment, especially families who are coping with poverty, historical trauma, structural racism, and other serious adversities (Bipartisan Policy Center, 2023). Researchers from the Brookings Institution (Glied & Aguilar, 2023) analyzed 2022 HRSA data and found that HRSA had designated 2774 of the 3144 counties in the country as mental health service shortage areas. Relatedly, increasing knowledge is needed to identify effective organizational staff wellness policies and practices for preventing and addressing secondary traumatic stress to increase retention rates among ECMH providers. A small body of literature suggests that

infant and early childhood mental health consultation (IECMHC) and use of evidence-based mental health treatments for children, for example, can have protective effects against job-related provider stress, emotional exhaustion, and turnover (Silver et al., 2023).

Future Directions

Together, the increasing numbers of young children, parents, and providers who develop mental health challenges and disorders, along with the vast unmet need for ECMH services, are cause for alarm. The stigma of mental health treatment along with the traditional approach used by many community mental health agencies (e.g., maintaining traditional work hours, long waitlists, requiring multiple intake visits prior to treatment) can be serious deterrents to families, who in turn may not be able to prioritize their child's or family's mental and physical wellness (Goodman et al. 2013).

In a brief co-authored by this chapter's first author, *A National Agenda for Children's Mental Health*, Bartlett and Stratford (2021) discuss the urgent need to address children's worsening mental health in the USA and related inequities. They recommend adopting a multipronged approach, particularly given the deleterious psychological impacts of the COVID-19 pandemic on children, parents, and service providers alike; the shortage of mental health providers; and inequities in the development of ECMH disorders, access to services, service quality, and outcomes achieved for families experiencing poverty, families of color, LGTBQ families, and those living in rural and other resource-poor geographical areas (Hodgkinson et al., 2017; Rathod et al., 2018). Accordingly, Bartlett and Stratford (2021, pp. 6–11) propose five overarching strategies to promote children's mental health:

1. Establish systems for coordinating mental health with other services that support children, youth, and families, including health care, child welfare, the legal system, home visiting, child care, and education.
2. Develop more flexible and equitable federal, tribal, state, and local funding streams that expand access to mental health promotion, prevention, early intervention, and treatment services.
3. Establish a national, cross-disciplinary initiative to increase workforce capacity in children's mental health.
4. Invest in innovative technology to increase access to mental health supports.
5. Increase children's well-being by reducing family poverty.

The National Academies of Science, Medicine, and Engineering (2023) examined the literature on the impact of the COVID-19 pandemic on child and family well-being and identified support for children's mental health as a high priority. Among the recommendations were developing a task force to address the pandemic's impacts and to focus on families who suffered the worst burdens (i.e., Black, Latino, and Native American children and families, and those living in poverty). They also

called for strengthening and expanding Medicaid coverage at the federal level "so that all children and families have consistent access to high-quality, continuous, and affordable physical and mental health services" (p. 8), as well as increasing federal investments to improve access to high-quality treatment and preventive services in clinical settings, communities, and schools. To address the role of poverty in mental health, NASEM asserted that additional efforts are needed to ensure parity across states and to mitigate the economic impacts of the pandemic (e.g., through cash transfers to families).

Ultimately, successful identification and treatment of mental health disorders in early childhood relies heavily on the extent to which providers, programs, and service models promote family engagement among diverse groups of young children. Research, practice, and policy on family engagement in ECMH services are still in the early stages, most services continue to exist in silos, and despite mounting evidence that coordinated and comprehensive systems of care are more likely to achieve the intended outcomes of early interventions, families who are already coping with stress of parenting young children with mental health problems are still required to negotiate the complexity of working with multiple service systems, and our most vulnerable families continue to face the most significant barriers to treatment. Expanded efforts are needed now to successfully engage and retain parents, families, and providers in services to promote the mental health and well-being of young children and their families.

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