

THE *Active* LEARNER

In Focus: Mental Health

An Interview With Nadine Burke Harris

Children of Trauma and the Developing Brain

Early Childhood Mental Health Endorsement

Also Inside:

Mental Health Screening

Supporting Families Coping With Addiction



From the President



By now, nearly all of us are familiar with the long-term societal benefits of early education. We know that high-quality early childhood care is good for the community, the nation, and the world.

But let's think for a moment not about how high-quality early education affects the community or the economy, but how the opportunity to receive that education affects even *one child*. To that child, high-quality early education is not about its positive effects on the statistical divorce rate; it's about

how his preschool offered him a place of refuge from a sometimes hostile world. To that one child, it's not about a drop in the overall crime rate; it's about how, with so much uncertainty at home, she found the confidence to persevere.

For high-quality early education to truly have a meaningful impact on society as a whole, every *one* has to have the opportunity for success — every individual. And that starts when we cultivate an environment of tolerance and respect in our classrooms, and when we acknowledge that, for some of our children, our classroom is a respite from a weary world. For some of the children in our care, a trauma-informed classroom may be the only stress-free place they know.

Before these children can explore their numbers and letters and their relationships to adults and children and the world around them, they — and their families — need to find that sense of safety, to meet basic human needs for security. Your classroom door can represent hope for children and families struggling with divorce, drug and alcohol abuse, depression, incarceration, and so much more.

I'm reminded of the often-told story of the girl who was spotted rescuing stranded starfish on the beach at low tide. A man, observing, was struck by her persistence. He laughed a little. "There must be a million starfish on this beach," he said. "I applaud your hard work. But how much of a difference could it possibly make?"

The girl bent down and picked up a starfish as if to hand it to the man. Instead, she reared back and tossed it as far as she could into the ocean. She looked up at the man and said, "It made a difference to that one."

Early education can't solve all of society's problems. But if we can shift our vision from the macro to the micro, we can see the profound effect that early education can have on the children in our programs and in our communities. And knowing what we know about the social and emotional needs of growing children and their families that we can foster to promote success on both the individual *and* the community level, is there any higher calling than ours?

Cheryl Polk, PhD
President

THE *Active* LEARNER

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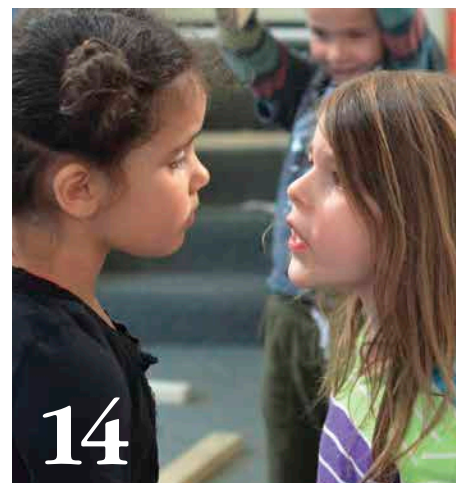
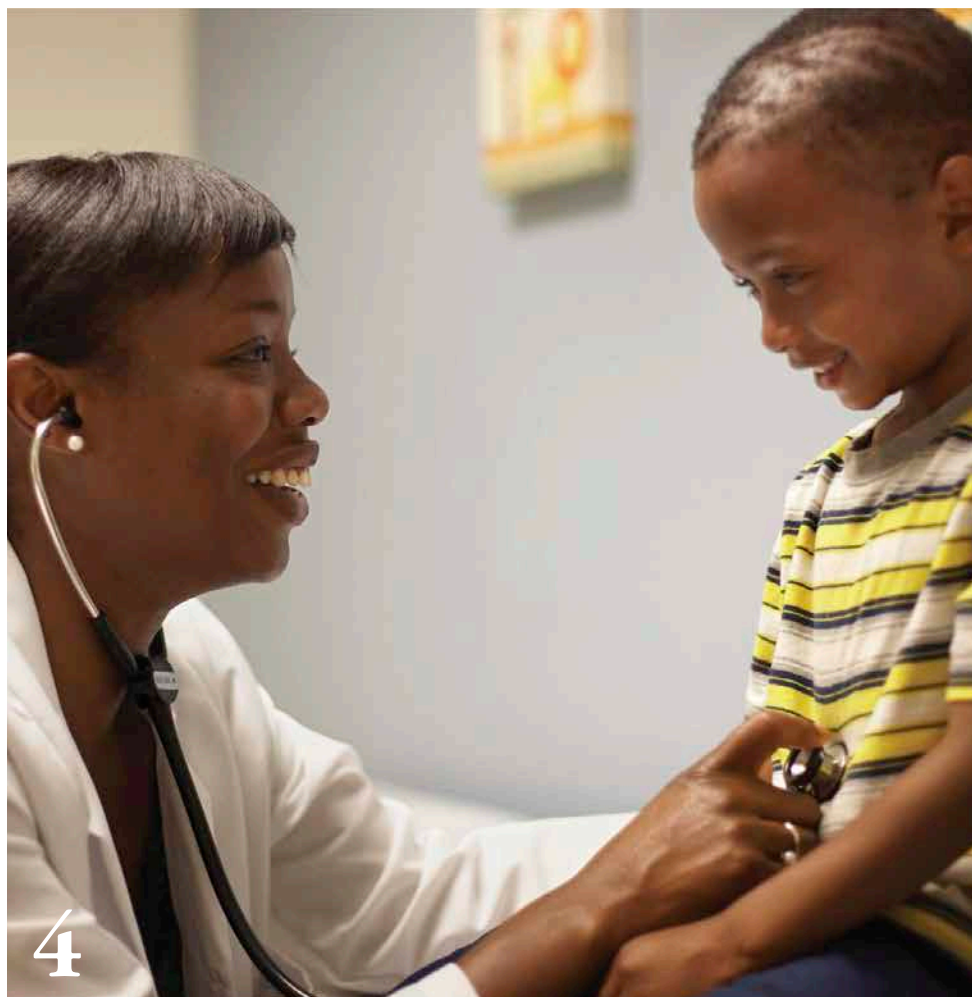
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Toxic Stress and the Future of Public Health

A Conversation With Dr. Nadine Burke Harris on Her Newest Book

BY JOANNE TANGORRA



From the home to the classroom to the pediatrician's office – we need a deeper understanding of the role of toxic stress in our children's lives.

In *The Deepest Well: Healing the Long-Term Effects of Childhood Adversity*, Dr. Nadine Burke Harris details her journey of discovery as she came to understand the critical link between toxic stress in early childhood and poor health outcomes that last a lifetime. In this interview, we talked to Dr. Burke Harris about the negative health effects of adverse childhood experiences (ACEs) and how to prevent lifelong consequences through innovative health interventions.

Q: In the introduction to *The Deepest Well*, you write that “childhood adversity is a story we think we know.” What are some of the assumptions we have about childhood adversity? What part of the story is, as you say, “missing”?

A: There are several assumptions about childhood adversity that are important to debunk. But perhaps the most important is the assumption that childhood adversity only affects mental health. The truth is that there is an actual biological link between early traumatic experiences and damaged health. Another big piece of the story is the hopeful part: the overwhelming research to suggest that there is a known antidote to childhood adversity. Children who have experienced adversity are not damaged goods; they are not defective. If they can get a safe, stable, and nurturing environment at an early age, the biology says that this sets them up to develop a healthy stress-response system in adulthood. The fact that environment is something we can modify means there is a lot of hope for children who have experienced adversity.

Q: Can you tell us about a patient who changed your life/work?

A: For a long time, I had suspected that there might be a biological connection between early adversity and health, but it was Diego, a seven-year-old boy who stopped growing after a sexual assault, who really forced me to dig deeper. As a doctor, we do all of these complicated and expensive workups to determine the cause of our patients' health problems, but in this case the most important thing that we had to address was the trauma.



While childhood adversity certainly affects mental health, its physical effects are equally pervasive. The body's repeated response to toxic stress affects the brain, heart, and other body systems.

Q: At one point in your process to learn more about the effects of adverse childhood experiences, one of your colleagues handed you a study that had been published in 1998. What excited you about this study and what impact did it have on your own work? Did you have any “ah-ha” moments?

A: Reading the landmark ACE Study for the first time changed everything. It helped to make sense of everything I had experienced in my years of practice and all the questions and observations that I hadn't been quite able to put together. I was excited about how robust the study was: It included data from a huge sample of more than 17,000 people. I was excited to finally feel like I was seeing the full reality of what was happening to my patients' bodies, and also the *how* and *why*. It completely changed the way I practice medicine and altered the trajectory of my career from being a pediatrician to becoming a pediatrician, advocate, activist, and author.

Q: What surprised you about your work in ACEs?

A: When I first started my research into toxic stress, I had no idea that childhood adversity could change the way our DNA was read and transcribed. I never learned about that in medical school. That really blew me away. I was also surprised by the hopeful aspect! For me, this science is incredibly hopeful. ACEs

have been happening since Day 1, but this science represents an amazing breakthrough in helping us interrupt the progression from early adversity to disease and early death.

“When kids are exposed to a serious stressor, like immigration or the death of a loved one, they require safe, stable, and nurturing relationships to help regulate the activation of the stress response and ultimately heal and restore balance.”

Q: Would you explain the difference between a “tolerable stress response” and a “toxic stress response”?

A: The critical difference between the tolerable stress response and the toxic stress response is the presence of a buffering caregiver. When kids are exposed to a serious stressor, like immigration or the death of a loved one, they require safe, stable, and nurturing relationships to help regulate the activation of the stress response and ultimately heal and restore balance — building resilience. Adverse childhood experiences (ACEs), such as neglect or having a parent or caregiver who is struggling with substance abuse or mental illness, are a double whammy because they simultaneously activate the stress response *and* interfere with the caregiving that would buffer that stress effect. The result is the toxic stress

Feature

response, in which overactivation of the stress response leads to long-term changes in the child's body and brain. This can result in harm to both physical and mental health, in childhood and throughout the life course.

Q: *What are the effects of toxic stress?*

A: Chronic overactivity of the stress response affects many body systems, including the brain, immunity, the heart, and hormones and development. Toxic stress can impair executive functioning. It can also affect a child's moods and feelings. Toxic stress can also affect the immune system, making it harder for bodies to fight off infection and illness and increasing the risk for conditions like asthma, eczema, and food allergies. Toxic stress can lead to damage to the arteries and increase the risk of heart disease, stroke, and other serious health issues later in life. Toxic stress can also impact growth and development. It can also lead to obesity and changes in the timing of puberty, as well as other issues.

Q: *You discuss that the effects of toxic stress are sometimes misdiagnosed as symptoms of ADHD?. How does that complicate the diagnosis of ACEs?*

A: For a child who is disorganized, distracted, impulsive, and forgetful, the cause can be either ADHD or toxic stress. Stimulants (like Ritalin) are the number one treatment for ADHD, where the

problem is thought to be underactivity of the prefrontal cortex, the part of the brain responsible for executive functioning. But an overload of stress hormones can also interfere with executive functioning. This is why it's so important for a doctor to include an ACE Score as part of the clinical assessment for ADHD. If the ACE Score is high, the treatment is to reduce the "dose" of adversity and enhance the capacity of the caregiver in the child's life to be a protective buffer. In our practice, when medications are necessary for our kids with toxic stress, we avoid stimulants. Rather, we start with a medication that was originally designed as a blood pressure lowering medication, Guanfacine, because it has been found to help regulate the stress response. For the vast majority of our patients, this approach of the right supports coupled with medications that address their stress biology is much more effective than stimulants.

Q: *In one chapter of your book, you discuss how it is that ACEs are "handed down so reliably from generation to generation." Would you explain how that happens? Is there a way to interrupt the legacy of multigenerational ACEs?*

A: Part of the reason that ACEs are intergenerational is that parents who have experienced trauma in their childhoods, without the buffering of a caregiver, may have developed an overactive stress response, which can increase their risk for both physical, mental,



All humans are dependent on "therapeutic interactions" — understanding, compassion, and empathy — to buffer the toxic stress in their environment. All adults — especially educators — have the capacity to provide these therapeutic interactions.

I’ve seen what a difference early identification and early intervention has made for my patients with ACEs, and like others, I found myself on a mission to ensure every kid across the country has the same chance at successful treatment.

and behavioral health concerns. Parents with an overactive stress response may have more difficulty managing stress and emotions and self-regulating in a healthy manner when engaging with their kids, which can affect how they parent. This dynamic may lead to more adverse outcomes when parents engage with their children, and can perpetuate the intergenerational cycle. Breaking the cycle includes improving supports for parents, like education, mental health screening and care, and other support services.

Q: *When did you realize that the work you were doing would have to reach beyond where it started, at the Bayview Clinic?*

A: I’ve seen what a difference early identification and early intervention has made for my patients with ACEs, and like others, I found myself on a mission to ensure every kid across the country has the same chance at successful treatment. That meant we needed to share our screening tool and methods. The Center for Youth Wellness made our ACE screening protocol available for free online and we were surprised and delighted to see over 1,200 clinics and practitioners in 15 countries download the tool in just one year. In talking to doctors who had started screening for ACEs, they all said that they would never go back to not screening. It’s like a bell you can’t unring. Given the positive feedback, we created a network for pediatricians around the country to learn together about how to screen, what to do with a positive screen, and how to advance the care of children with toxic stress faster. We’ve also recognized the need to educate parents and caregivers about the impacts of toxic stress and how they can help protect and heal their little ones. So, we’ve launched a national public education campaign called Stress Health (stresshealth.org) to do just that. It’s my hope that our National Pediatric Practice Community on ACEs (nppcaces.org) and our Stress Health education campaign will bring us closer to the day when all families have the tools they need to protect their children and ACE screening is a universal part of health care.

Q: *How does the problem of ACEs extend beyond one community to the entire population?*

A: The original ACE Study was conducted in a population that was 70% Caucasian and 70% college-educated. In my travels around the country and around the world, I have heard so many communities say “ACEs are impacting my community!” They impact white kids, black and brown kids, rich, poor, urban, rural


— in other words, trauma can affect anyone and it can happen anywhere. ACEs and toxic stress thrive on secrecy and shame, both at the individual level and at the societal level. We can’t treat what we refuse to see. That’s why at the Center for Youth Wellness, we are working to make sure that every pediatrician in America screens for ACEs as a routine part of care.

Q: *Why is it so important to understand ACEs?*

A: In order to effectively prevent and treat serious health conditions like diabetes, asthma, depression, and cancer, we need to understand that ACEs are a major risk factor that has previously gone unidentified. While I believe that it is critical that pediatricians understand and screen for ACEs in a primary care setting, enough kids are being sent to my clinic by teachers requesting a diagnosis of ADHD and medications that I also recognize that the doctor’s office isn’t the only place that needs fundamental understanding of toxic stress.

No matter who we are, there is a role for each of us in protecting and supporting young people. For educators, consider talking to your school leaders about adopting trauma-informed approaches that support young people — instead of excluding them — when they are showing symptoms of toxic stress. I invite all of you to be part of the revolution in how society understands and responds to ACEs. Together, we have an opportunity to create a healthier future for children everywhere.

Q: *In your epilogue at the end of The Deepest Well, you imagine the year 2040 when every child receives an ACEs screening along with routine vaccinations and a TB test. What else do you envision for children and public health in that future?*

A: Famed child psychiatrist Dr. Bruce Perry talks about the healing power of “therapeutic interactions” for kids who have experienced trauma. I believe that everyone has the capacity to provide these healing interactions for kids, especially educators. I believe that by raising awareness among everyone from teachers to bus drivers to police officers, we can maximize the “cumulative dose” of healing interactions for children in our communities. 

Dr. Burke Harris is the founder and CEO of the Center for Youth Wellness in San Francisco. Her TED Talk, “How Childhood Trauma Affects Health Across a Lifetime,” has over three million views.

Excerpt From *The Deepest Well*: Healing the Long-Term Effects of Childhood Adversity

BY NADINE BURKE HARRIS, MD

Kayla and Diego were just two patients, but they had plenty of company. Day after day I saw infants who were listless and had strange rashes. I saw kindergartners whose hair was falling out. Epidemic levels of learning and behavioral problems. Kids just entering middle school had depression. And in unique cases, like Diego's, *kids weren't even growing*. As I recalled their faces, I ran an accompanying mental checklist of disorders, diseases, syndromes, and conditions, the kinds of early setbacks that could send disastrous ripples throughout the lives to come.

If you looked through a certain percentage of my charts, you would see not only a plethora of medical problems but story after story of heart-wrenching trauma. In addition to the blood pressure reading and the body mass index in the chart, if you flipped all the way to the Social History section, you would find parental incarcerations, multiple foster-care placements, suspected physical abuse, documented abuse, and family legacies of mental illness and substance abuse. A week before Diego, I'd seen a six-year-old girl with type 1 diabetes whose dad was high for the third visit in a row. When I asked him about it, he assured me I shouldn't worry because the weed helped to quiet the voices in his head. In the first year of my practice, seeing roughly a thousand patients, I diagnosed not one but two kids with autoimmune hepatitis, a rare disorder that typically affects fewer than three children in one hundred thousand. Both cases coincided with significant histories of adversity.

I asked myself again and again: *What's the connection?*

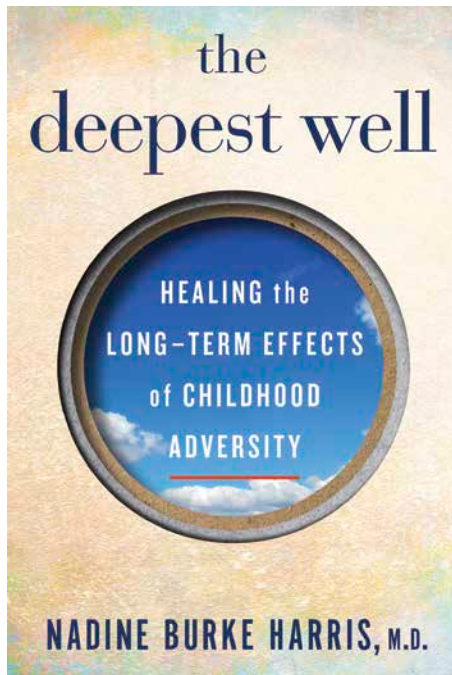
If it had been just a handful of kids with both overwhelming adversity and poor health outcomes, maybe I could have seen it as a coincidence. But Diego's situation was representative of hundreds of kids I had seen over the past year. The phrase *statistical significance* kept echoing through my head. Every day I drove home with a hollow feeling. I was doing my best to care for these kids, but it wasn't nearly enough. There was an underlying

sickness in Bayview that I couldn't put my finger on, and with every Diego that I saw, the gnawing in my stomach got worse.

For a long time the possibility of an actual biological link between childhood adversity and damaged health came to me as a question that lingered for only a moment before it was gone. *I wonder ... What if ... It seems like ...* These questions kept popping up, but part of the problem in putting the pieces together was that they would emerge from situations occurring months or sometimes years apart. Because they didn't fit logically or neatly into my worldview at those discrete moments in time, it was difficult to see the story behind the story. Later it would feel obvious that all of these questions were simply clues pointing to a deeper truth, but like a soap-opera wife whose husband was stepping out with the nanny, I would understand it only in hindsight. It wasn't hotel receipts and whiffs of perfume that clued me in, but there were plenty of tiny signals that eventually led me to the same thought: *How could I not have seen this? It was right in front of me the whole damn time.*

I lived in that state of not-quite-getting-it for years because I was doing my job the way I had been trained to do it. I knew that my gut feeling about this biological connection between adversity and health was just a hunch. As a scientist, I couldn't accept these kinds of associations without some serious evidence. Yes, my patients were experiencing extremely poor health outcomes, but wasn't that endemic to the community they lived in? Both my medical training and my public health education told me that this was so.

That there is a connection between poor health and poor communities is well documented. We know that it's not just how you live that affects your health, it's also *where* you live. Public-health experts and researchers refer to communities as "hot spots" if poor health outcomes on the whole are found to be extreme in comparison to the statistical norm. The dominant view is that health disparities in populations like Bayview occur because



these folks have poor access to health care, poor quality of care, and poor options when it comes to things like healthy, affordable food and safe housing. When I was at Harvard getting my master's degree in public health, I learned that if I wanted to improve people's health, the best thing I could do was find a way to provide accessible and better health care for these communities.

“That there is a connection between poor health and poor communities is well documented. We know that it's not just how you live that affects your health, it's also where you live.”

Straight out of my medical residency, I was recruited by the California Pacific Medical Center (CPMC) in the Laurel Heights area of San Francisco to do my dream job: create programs specifically targeted to address health disparities in the city. The hospital's CEO, Dr. Martin Brotman, personally sat me down to reinforce his commitment to that. My second week on the job, my boss came into my office and handed me a 147-page document, the 2004 *Community Health Assessment* for San Francisco. Then he promptly went on vacation, giving me

very little direction and leaving me to my own ambitious devices (in hindsight, this was either genius or crazy on his part). I did what any good public-health nerd would do — I looked at the numbers and tried to assess the situation. I had heard that Bayview Hunters Point in San Francisco, where much of San Francisco's African American population lived, was a vulnerable community, but when I looked at the 2004 assessment, I was floored. One way the report grouped people was by their zip code. The leading cause of early death in seventeen out of twenty-one zip codes in San Francisco was ischemic heart disease, which is the number-one killer in the United States. In three zip codes it was HIV/AIDS. But Bayview Hunters Point was the only zip code where the number one cause of early death was violence. Right next to Bayview (94124) in the table was the zip code for the Marina district (94123), one of the city's more affluent neighborhoods. As I ran my finger down the rows of numbers, my jaw dropped. What they showed me was that if you were a parent raising your baby in the Bayview zip code, your child was two and a half times as likely to develop pneumonia [as] a child in the Marina district. Your child was also six times as likely to develop asthma. And once that baby grew up, he or she was *twelve* times as likely to develop uncontrolled diabetes.

I had been hired by CPMC to address disparities. And, boy, now I saw why.

Looking back, I think it was probably a combination of naiveté and youthful enthusiasm that spurred me to spend the two weeks that my boss was gone drawing up a business plan for a clinic in the heart of the community with the greatest need. I wanted to bring services to the people of Bayview rather than asking them to come to us. Luckily, when my boss and I gave the plan to Dr. Brotman, he didn't fire me for excessive idealism. Instead, he helped me make the clinic a reality, which still kind of blows my mind.

The numbers in that report had given me a good idea of what the people of Bayview were up against, but it wasn't until March of 2007, when we opened the

doors to CPMC's Bayview Child Health Center, that I saw the full shape of it. To say that life in Bayview isn't easy would be an understatement. It's one of the few places in San Francisco where drug deals happen in plain sight of kindergartners on their way to school and where grandmas sometimes sleep in bathtubs because they're afraid of stray bullets coming through the walls. It's always been a rough place and not only because of violence. In the 1960s, the U.S. Navy decontaminated radioactive boats in the shipyard, and up until the early 2000s, the toxic byproducts from a nearby power plant were routinely dumped in the area. In a documentary about the racial strife and marginalization of the neighborhood, writer and social critic James Baldwin said, “This is the San Francisco that America pretends does not exist.”

My day-to-day experience working in Bayview tells me that the struggles are real and ever present, but it also tells me that's not the whole story. Bayview is the oily concrete you skin your knee on, but it's also the flower growing up between the cracks. Every day I see families and communities that lovingly support each other through some of the toughest experiences imaginable. I see beautiful kids and doting parents. They struggle and they laugh and then they struggle some more. But no matter how hard parents work for their kids, the lack of resources in the community is crushing. Before we opened the Bayview Child Health Center, there was only one pediatrician in practice for over ten thousand children. These kids face serious medical and emotional problems. So do their parents. And their grandparents. In many cases, the kids fare better because they are eligible for government-assisted health insurance. Poverty, violence, substance abuse, and crime have created a multigenerational legacy of ill health and frustration. But still, I believed we could make a difference. I opened my practice there because I wasn't okay with pretending the people of Bayview didn't exist. 🌊

Normalizing Early Childhood Mental Health Awareness

How to Provide Ongoing Support for Families That Are Coping With Addiction

INTERVIEW BY SAMANTHA SMITH



For some children, your classroom is the only respite they get from the toxic stress beyond school doors.

When addiction or substance abuse is present in a child's home life, it's an indication for caregivers to pay close attention to the social, emotional, and mental health of that child. We've asked three early childhood professionals — Kimberly Diamond-Berry, Kathy Laurus, and Jennifer Novak — for their expertise on how to support the children you care for every day if they've been born into a home affected by substance abuse, what resources you can offer families, and how to normalize early childhood mental health awareness.

WHAT IS THE BEST WAY TO EFFECTIVELY TEACH AND SUPPORT CHILDREN EMOTIONALLY WHEN MANY LIVE IN STRESSFUL ENVIRONMENTS? WHAT ADVICE CAN YOU GIVE TO TEACHERS?

Diamond-Berry: For infants, toddlers, and preschoolers who live under ongoing stressful circumstances, their little bodies are in a constant state of the "fight or flight" response, and living in this prolonged state is detrimental to healthy brain growth, social-emotional development, and learning. Living in ongoing stressful environments with no relief can actually alter the physical structure of the brain. For many of these young children, your classroom is often the only time they get to experience life in a stress-free zone. Teachers have an important role to play in these children's lives, as they can facilitate daily routines, experiences, and learning opportunities for young children free of stress and fear, and help to create a world where they can play, explore, and learn.

Laurus: The best way to effectively teach and support children emotionally is to always be there, filling in what they may be missing from their most basic needs. Perhaps a child is coming to school tired. You give them a safe place where they can sleep — even if it's their napping cot or the couch in your book area. If they are coming to school hungry, you provide them with multiple opportunities to eat nutritious foods. If they are coming to school without a jacket, you put a jacket on that child. If a child's

basic needs are not met, they won't be able to focus on anything beyond that.

However, just as it is important to be there for the child, it is equally important to be there for the parents. Keep reaching out to the family by phone or in person at home visits. The more contact you have with a family, the stronger the relationship becomes and the more the parents trust you to allow you in to provide assistance to them and their children.

“Parents, families, or children who are required to travel to several different locations for resources or services...will often discontinue treatment simply because it becomes too challenging to get to all of the services needed or prescribed for them.”

Novak: When children live in stressful environments, it can seem like you are powerless to help them. However, the classroom environment and how well a child is connected to a group of supportive adults is a significant mitigating factor for children who are otherwise surviving stress and trauma. One of the ways teachers and other educational providers can be effective in these circumstances is to provide a “trauma-informed classroom” — which means creating a space in the educational environment where children feel safe and supported. This can be done in many different ways: from giving children a physical space to cool off when they feel overwhelming emotions, building strong one-on-one relationships with children who are struggling, to designing the physical environment to be soothing. Ensuring that the emotional needs of young children are recognized and validated, just as much as their educational needs, has an enormous impact on their ability to learn.

WHAT ARE SOME OF THE BEST RESOURCES YOU ARE AWARE OF FOR FAMILIES WITH YOUNG CHILDREN WHO ARE COPING WITH ADDICTION?

Diamond-Berry: Studies show that parents, families, or children who are required to travel to several different locations for resources or services will likely become discouraged, have trouble finding transportation, and will often discontinue treatment simply because it becomes too challenging to get to all of the services needed or prescribed for them. Therefore, addiction treatment



We prepare each child for success by first ensuring that their basic needs — for food, shelter, and emotional support — are being met.

facilities offering comprehensive services for families, parents, and children can offer some of the best resources.

In the last 10–20 years, more addiction treatment programs have been designed with an understanding of the unique role caregiving responsibilities play in supporting recovery. In fact, expectant and parenting women are more likely to alter their substance abuse if they are able to be placed in a safe, nurturing, and stable environment with their children.



Kim Diamond-Berry, PhD, is Associate Director of Research and Early Childhood Strategies for HighScope with over 30 years of experience in early childhood education and infant and early childhood mental health. She is Infant Mental Health endorsed and a licensed clinical psychologist in Michigan and Virginia.



Kathy Laurus teaches in the Dearborn (MI) Public School district, and has been in the early childhood field for fifteen years. For eleven of those years, she worked in the Great Start Readiness Program (GSRP) with at-risk students. She has a bachelor's degree in science education with a State of Michigan Early Childhood Education endorsement.



Jennifer Novak serves as a Senior Writer Training Specialist with the Military Family Projects team at ZERO TO THREE. She has over five years of direct-practice social work experience in fields such as family violence, pediatric hospice, substance abuse, and high-risk family case management, and over five years' experience in training and policy content development.



Don't be afraid to talk about mental health with families in your program. Being open and receptive to discussion can help to destigmatize mental health issues and provide guidance for families to seek the help they need.

The Substance Abuse and Mental Health Services Administration (SAMHSA) offers a national helpline (1-800-662-HELP [4357]), and also an online Behavioral Health Treatment Services Locator, which is anonymous, secure, and confidential. Your program's Infant and Early Childhood Mental Health Consultant (IECMHC) would also be a good source for helping families locate the best services in their community.

Novak: For families suffering with addiction who also have young children, the best resource is to link them directly to a treatment provider. Infants and toddlers are at especially high risk for experiencing abuse and neglect from a parent who is addicted to a substance, and in order for that risk to reduce, the parent needs to receive help attaining and maintaining sobriety. Every community will have varying degrees of treatment options, and a parent's access to health insurance can help — or hinder — the number of options they have. At the very least, meeting-style intervention such as Alcoholics Anonymous or Narcotics Anonymous can be a life saver for many addicted individuals. Many communities also offer services such as Al-Anon or Alateen meetings specifically for those living with an addicted person. Finally, family-based therapeutic intervention can be a helpful service to repair some of the damage addiction causes in the family system. The best

place to start in locating these services locally is to contact your local chapter of the United Way by calling 211.

WHAT ARE SOME OF THE BEHAVIORAL EFFECTS EXPERIENCED BY YOUNG CHILDREN WHO LIVE IN FAMILIES STRUGGLING WITH ADDICTION? WHEN SHOULD REFERRAL FOR INTERVENTION OCCUR? HOW CAN WE SUPPORT THE CHILDREN WHOSE FAMILIES DON'T WANT HELP OR DENY IT?

Diamond-Berry: For young children, behavior is communication. Teachers and caregivers are in what is likely one of the few settings in which these children's needs will be acknowledged, so our responses are critical. Sometimes providing a setting where young children receive the attention they need, get their needs met, are able to express their feelings, and can learn, explore, and play in a stress-free environment on a consistent basis is enough.

However, when the young children in our care are inconsolable, aggressive, or paralyzed by fear more often than they are able to learn or explore, referral to your program's IECMHC or social worker would be advised. Remember that as a caregiver or teacher, you likely spend as much time with the young children in your

care as their parents and families. If you notice a behavior that does not seem quite right and you are in doubt, don't hesitate to seek consultation with a peer, supervisor, or your IECMHC.

There are many reasons why families may choose not to accept support and help from a school or child care center (e.g., fear, lack of trust, cultural values, etc.). Sometimes families believe that they will be looked down upon for accepting help. The reality is, as caregivers, we have to focus on what we can control. Though we cannot force a family to accept help, we can ensure that the family understands what the child needs to succeed.

Laurus: The behavioral effects are constantly changing. There is not necessarily one set of behaviors a teacher might see in their classroom to make them think, "Oh, this is what's going on here." Occasionally children can be defiant or physically aggressive in the classroom. More often though, it's the smaller things such as being regularly tardy for school; high absences during the school year; the family frequently moving from place to place; constantly changing phone numbers; or, more obviously, even just the student repeating things that were seen/heard at home that clue you in to some form of substance abuse or even mental illness happening in the home.

“Ensuring that the emotional needs of young children are recognized and validated, just as much as their educational needs, has an enormous impact on their ability to learn.”

For the families who don't or won't accept the help a school can provide, as a teacher, I have gone to our social worker to get ideas on how to support the student in question. I have also been able to speak with the teachers of my students' siblings to loop more of the family into the same supportive web of the classrooms, so we can make adaptations together in multiple classrooms at the same time.


There have also been times when a family would not accept help from me, but they would accept it from other resources in the

building, such as the parent liaison. When help lines are continuously coming from a variety of directions, eventually a parent will grab onto one — even if it's not that school year.

HOW CAN WE NORMALIZE MENTAL HEALTH AWARENESS IN THE FIELD OF EARLY CHILDHOOD AND IN EARLY CHILDHOOD CLASSROOMS?

Diamond-Berry: Normalizing mental health awareness will not happen overnight. It takes ensuring that all staff are aware of, understand, and are comfortable embracing and promoting mental health awareness as an important aspect of the overall program — much like promoting other health and safety information and other family and community resources. This should be immediately evident to families who enter a program/facility for the first time. IECMH information and resources should be shared with the family just like other health and safety information about the program. For instance, if your program has an IECMHC or social worker, a first-time family should meet them just as the family would meet the nurse for any future physical health concerns.

Novak: The notion of mental health in early childhood is still a very new area of practice, and it becomes even more complicated as early childhood educators, who may have no experience with the subject, are key in making this a priority with families. One of the top needs is to help ensure that the early childhood workforce is effectively trained in the basics of infant and toddler mental health and the impacts of trauma on young children. Early childhood providers, whenever possible, should focus on developing strong professional connections to infant mental health providers and other intervention services to help create the network needed to effectively help families across systems.

Finally, don't be afraid to talk about mental health! Make it part of the discussions teachers have with families, have resource materials available to parents, and work with mental health consultants if needed. 



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When “It Depends” Is Not Enough to Advance the ECE Profession

BY MARICA COX MITCHELL



What is the name of your profession? When you say child care provider, do you mean early childhood educator or teacher? What does it take to become a part of your profession? What does your profession do? What standards guide your profession?

From the time I began my journey as an early childhood educator in 1998 until now, the early childhood education field

has always answered these questions about our loosely defined profession with...*it depends*.

Our name as a profession? *It depends* on the setting — home, center, or school?

Our qualification requirements? *It depends* on the type of funding a program receives — Head Start, Early Head Start, CCDBG, public pre-K, public K-12, or family tuition?

Our practice expectations? *It depends* on the facility's quality drivers — child care licensing standards, QRIS expectations, public K-12 priorities, or national professional accreditation?

Our compensation “ask”? *It depends* on the policy approach — increase the minimum wage, provide tax credits, or compensation alignment with K-12 public schools?

The good news is that public interest and discourse focused on the compensation and effectiveness of the early childhood workforce have heightened. The *Washington Post*, *EdWeek*, *NPR*, the *Atlantic*, *US News* and the *New York Times* recently featured stories about this workforce crisis. This level of external public discourse can create the social movement we need to advance the profession.

The challenging news is that our *it depends* response is no longer acceptable for basic questions about the identity of our early childhood education profession. We can't make a strong case for billions of dollars in public funding for compensation with...*it depends*. Internally, the early childhood field must lead this discourse and commit to offering a more concrete and unifying front to replace such conditional responses. If we don't, voters and public officials will fill the gaps in ways that may be harmful

to young children and our practice. As Sara Mead, a partner with Bellwether Education Partners, puts it, “A field that can't debate important issues internally is ill-equipped to respond to pushback from external critics.”

“Like other professions, we must be willing to unify and define (and continuously refine!) our profession and practice.”

So how do we mobilize ourselves? The Power to the Profession initiative (<https://www.naeyc.org/our-work/initiatives/profession/national-organizations>) has provided a platform for such an internal, field-led conversation to establish a unifying framework for career pathways, knowledge and competencies, qualifications, standards, and compensation. Like other professions, we must be willing to unify and define (and continuously refine!) our profession and practice. We must be willing to connect preparation, effectiveness, and compensation. We must be proactive and put forth the accountability standards we want. And we must do all this while preserving our commitment to diversity and equity. This will require creative, emotional, and cognitive labor from all of us.

But this is the least we can do. Doing so honors our elders (like teachers participating in the Ypsilanti Perry Preschool research we often cite) who brought us this heightened visibility. It lightens the load of the educators (including program administrators and faculty) who are making personal sacrifices at this moment to carry the broken early childhood system on their backs. And it empowers the future profession to build on the firm foundation we lay.

Just like nurses aligned and advanced their profession to better serve their patients, we too must do the same to better support the young children and families we serve. Let's lead our profession out of this ambiguous *it depends* phase. We know what young children and families need from us. We know what we need to be effective. We've come a long way together. Let's unite and move forward with greater clarity and coherence. If not us, who? If not now, when? 📌

Marica Cox Mitchell is the Deputy Executive Director, Early Learning Systems at the National Association for the Education of Young Children (NAEYC).



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The Emotional Backpack: Managing Conflict Resolution With Children of Trauma

“Students who are loved at home come to school to learn, and students who aren’t come to school to be loved.” ~ Nicolas Ferroni

BY CARLY LY

It’s the beginning of the school year. Classrooms are being stocked with materials to welcome children into the learning environment. Teachers put letter links or names of their students above each hook that will hold the backpack of the student. Yet, what arrives in the “backpack” of a child who has experienced trauma is often loaded not with tools for learning — but tools for survival.

The “emotional backpack” that a child brings to school is one that they cannot hang on a hook. It is filled with life experiences that they will bring into the classroom each and every day. The weight of that backpack is determined by earlier relationships with primary caregivers and the presence (or absence) of supportive environments. For some, the backpack is filled with life experiences that are negative and heavy, but balanced with those that are positive and light. These children operate from higher-level brain functioning and have access to social control, planning, memory, and differentiation of conflicting thoughts. They had a caregiver who carried the backpack for them at times and, through co-regulation in the early years, gave them the tools to self-regulate and manage their emotions (Downey, 2013).

For children of trauma, most of those life experiences have been negative, and the backpack remains heavy. No one carried the accumulated weight of that trauma for them, or taught them how to carry it. These students operate from a primal state of fight or flight, with their backpack full of the instincts and impulses necessary to survive in what has been an unsafe world. Exposure to trauma can interfere with a child’s ability to access higher-level executive function skills, such as the ability to problem solve, initiate and maintain healthy interpersonal relationships, and resolve conflict. These children cannot self-regulate because they were never given the experience of co-regulation with a healthy adult (Downey, 2013).

TRAUMA AND THE DEVELOPING BRAIN

Sara, a three-year-old preschooler, was born to parents who struggled with mental illness. She was surrounded by frequent outbursts of anger and violence. It is likely that both parents were unable to identify or respond to Sara’s physical or emotional needs.

In her classroom, Sara exhibits signs of poor cooperative play skills. When a child tries to engage in play with Sara, she either responds with outbursts of anger or she withdraws. When approached by the teacher to resolve conflicts, Sara either runs away or acts defiantly.

Let’s not ask ourselves “What is wrong with Sara?” but rather “What is going on with Sara?”

“Children of trauma cannot think through the emotions and situations they encounter because they only know how to react, and therefore, cannot think through steps of conflict resolution on their own.”

In this case, trauma has changed the chemical and physical structures of her brain. Sara’s aggression, defiance, and withdrawal are symptoms of traumatic stress. Teachers often confuse Sara’s behaviors for attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), or autism spectrum disorder (ASD) — which is understandable. Signs of trauma often look very similar to these disorders. Inattentive, hyperactive, and impulsive behavior often mirrors the effects of trauma (Ruiz, 2017).

If you are a teacher, you will be teaching children who have been traumatized. The Center for Disease Control and Prevention’s Adverse Childhood Experiences (ACE) Study tells us that more than 50% of students in a classroom have experienced one or



Children who experience trauma in their home environment have a more difficult time with problem solving, interacting with adults and other children, and resolving conflicts.

more adverse childhood events (Stevens, 2013). In this study, some types of childhood adversity measured include

- Physical, sexual, and verbal abuse
- Physical and emotional neglect
- Alcoholic, addicted, or mentally ill parent
- Frequent abuse in the home environment
- Loss of a parent to divorce or abandonment
- Incarcerated family member

Research indicates that children with four or more ACEs are 32 times more likely to have behavioral problems (Stevens, 2012). So, a child in your classroom who responds or acts like Sara may in fact be demonstrating behaviors that result from living with trauma.

Children's brains develop in response to early experiences and children learn how to regulate stress through supportive environments and co-regulation by an early caregiver. When a child's stress response system is activated in the context of a supportive relationship, the physiological effects of stress are buffered, and the child is wired for learning. If buffering relationships are unavailable to the child and the stress response is extreme and long lasting, the child's brain will prioritize survival over learning, as the case example of Sara demonstrated.

The areas of children's brains that become the most developed are those that are the most frequently activated (Nelson & Tierney, 2009). Children who experience trauma live in constant terror and are not supported by a trusted adult in the regulation of their emotions. These children remain in the heightened state of fight, flight, or freeze and live in a constant state of real or perceived threat. The thinking brain that puts threats in context is underused,

Feature

which inhibits higher-order thinking skills necessary for rational thought, problem solving, and considering other people's perspectives. Children of trauma cannot think through the emotions and situations they encounter because they only know how to react, and therefore, cannot think through the steps of conflict resolution on their own.

ADDRESSING PRIVATE LOGIC IN CHILDREN WHO HAVE EXPERIENCED TRAUMA

Research supports the idea that by addressing the internal state or private logic that precedes a child's behavior, we can help children to learn to self-regulate and develop executive skills for conflict resolution (Soma, 2018). Therefore, before a teacher can begin to address the behaviors of the child, they must try to understand the *private logic* leading to the behavior.

Consider the following examples:

Behavior: Running, throwing, screaming, yelling, hiding

Private Logic: I will do whatever I have to do to let you know that I am terrified.

In this example, before conflict resolution can be successful, the teacher needs to establish safety for the child. When highly aroused and dysregulated, the child is not able to think clearly. The child will also be terrified by their own lack of control, which heightens the emotions further. They will need help to calm down.

Behavior: Lying, manipulation, insulting, threatening

Private Logic: I will do whatever I need to do to control you and your responses. I don't trust you and I need to survive.

In this example, a child who has experienced trauma may try to control the emotions of the adults in their lives. This climate of aggression is much more familiar to them than calm, considerate interactions. Practices that help teachers remain calm and avoid the power battles will be most effective. If you sense yourself feeling angry, hurt, or rejected, don't be afraid to take a moment to reflect, calm yourself, and then come back to the interaction once you've regained composure. Only when the child is calm will they have the capacity to engage in conflict resolution.

Behavior: Refusal, defiance

Private Logic: I will not do what you want me to do because if I do you will shame me or abandon me.

In this example, the child is demonstrating an intense shame response to a perceived failure and to the experience of direction from an adult. Being overwhelmed by shame increases dysregulation and often leads to aggressive outbursts (Downey, 2013). Before attempting conflict resolution, it is necessary that the child work toward healing from the shame. Providing compassionate, nurturing, and encouraging words at this time will help counter the fear and shame the child is experiencing.



Providing children with tactile, visual tools, like the Calm Down Kit (above) and the Cozy Cove (below), can help them to step outside of their survival brain instincts and prepare them to resolve conflicts.



Without safety and connection in a relationship with a trusted adult, conflict resolution is impossible for a child who has experienced trauma. Trauma interferes with consideration of consequences, appraisal of safety and danger, and the ability to govern behavior (Bath, 2015). Children of trauma are living in and acting from the survival brain and do not have access to executive functioning skills such as planning, memory, and problem solving. When their internal state is focused solely on surviving, they do not have the capacity to focus on learning how to resolve their own emotional issues, much less those involving others.

TOOLS FOR EASING INTO CONFLICT RESOLUTION

Before initiating the steps of conflict resolution (see sidebar on page 17), the internal state of a child who has experienced trauma needs to be addressed. By addressing the internal state that precedes behaviors, children learn to self-regulate and develop executive skills for conflict resolution. Here are some tools to help initiate a child's awareness of their internal state:

- **Calm Down Kit** — This kit can include a feelings check-in chart, glitter jars, play dough, and similar items that help the child to focus on being present with one item and easing into a more learning-ready state. Before introducing this kit and its contents, discuss with the child the changes they feel in their body when they get angry or frustrated. Empower them by displaying the contents and explaining the purpose of each component of the kit. Let the child know that it is okay if they try something and it doesn't work, or that it may take time for their body to learn how to calm down (Ethington, 2018).
- **Cozy Cove** — A "cozy cove" can be used as a place of comfort for a child to regain control or remove themselves from a triggering situation. This space should include comforting, calming, and soothing items that will add to serenity of the "cove." This space should be introduced to all children in the classroom and the teacher should demonstrate how to use it (Grogan, 2012).
- **Brain Breaks** — Children who grow up with emotionally unavailable caregivers have not learned how to self-soothe and have trouble staying focused for long periods of time. "Brain Breaks" are small and simple activities, only 2–3 minutes long, that get children moving to release energy during the day, and teach them to gain control of their actions. To help children cope in the classroom, plan time in the daily routine for "Brain Breaks" before behavior gets out of control (Young, 2018).

Trauma is such an overwhelming sensory experience that children of trauma often need concrete visual tools to bring them back to the present and teach them to step outside their survival brain instincts. What they see and feel can be more powerful than the words spoken to them, and giving them tactile, visual tools to cope can help them succeed.

- **Visual Schedules** — Children of trauma often worry about what comes next and have very little internal structure. Regular routines in the classroom and support of the child during transitions

HighScope's Six Steps of Successful Conflict Resolution

When the internal state of a child with trauma has been addressed, you can scaffold children's understanding of conflict resolution by following the six steps below.

1. APPROACH CALMLY, STOPPING ANY HURTFUL ACTIONS.

- Place yourself between the children, on their level.
- Use a calm voice and gentle touch.
- Remain neutral rather than take sides.

2. ACKNOWLEDGE CHILDREN'S FEELINGS.

- "You look really upset."
- Let children know you need to hold any object in question.

3. GATHER INFORMATION.

- "What's the problem?"

4. RESTATE THE PROBLEM.

- "So the problem is ..."

5. ASK FOR IDEAS FOR SOLUTIONS AND CHOOSE ONE TOGETHER.

- "What can we do to solve this problem?"
- Encourage children to think of a solution.

6. BE PREPARED TO GIVE FOLLOW-UP SUPPORT.

- "You solved the problem!"
- Stay near the children.

From *You Can't Come to My Birthday Party* (2nd ed.) by Betsy Evans, 2016, Ypsilanti, MI: HighScope Press, pp. 23–30. © 2016 HighScope Educational Research Foundation.

Feature

will help the child develop internal structure. HighScope's Daily Routine Cards are a great example of a visual schedule.

- **Emotional Literacy Charts** — Putting feelings into words activates the higher-level functioning of the brain and puts the brakes on the survival brain. It allows us to make meaning of experience and gain a sense of control. These charts give children a concrete feeling to point to, which helps them not only feel a sense of control over their emotions, but helps you discern how to talk about their feelings with them.

“When their internal state is focused solely on surviving, children do not have the capacity to focus on learning how to resolve their own emotional issues, much less those involving others.”

As teachers and caregivers of children who have experienced trauma, we need to be reasonable with our expectations. Even after a day, month, or year of working with a child, the child may still have outbursts, run away, or rarely engage in anything — much less in conflict resolution. Because of this, often teachers feel defeated or believe that they didn't accomplish anything for the child; however, research indicates that school connectedness is the number one protective factor for children who have experienced trauma (Hardison, 2017). Because as Urie Bronfenbrenner put it, “somebody's got to be crazy about that kid.”

But what does ‘crazy’ mean? It means that the adult in question regards this particular child as somehow special — for the child, the adult is also special — someone to whom the child turns most readily in trouble and in joy, and whose comings and goings are central to the child's experience and well being. (Bronfenbrenner, p. 32)

Your classroom may be the only place a child gets to experience emotional stability and safety, and learns how to self-regulate. Even if it may be for the first time in their life, giving them the tools to access their emotions and engage in conflict resolution will help their brains develop at a pace at which academic learning can truly begin. 🧠

For a list of references used in this article, please see the online version of this issue of *The Active Learner*, at HighScope.org.

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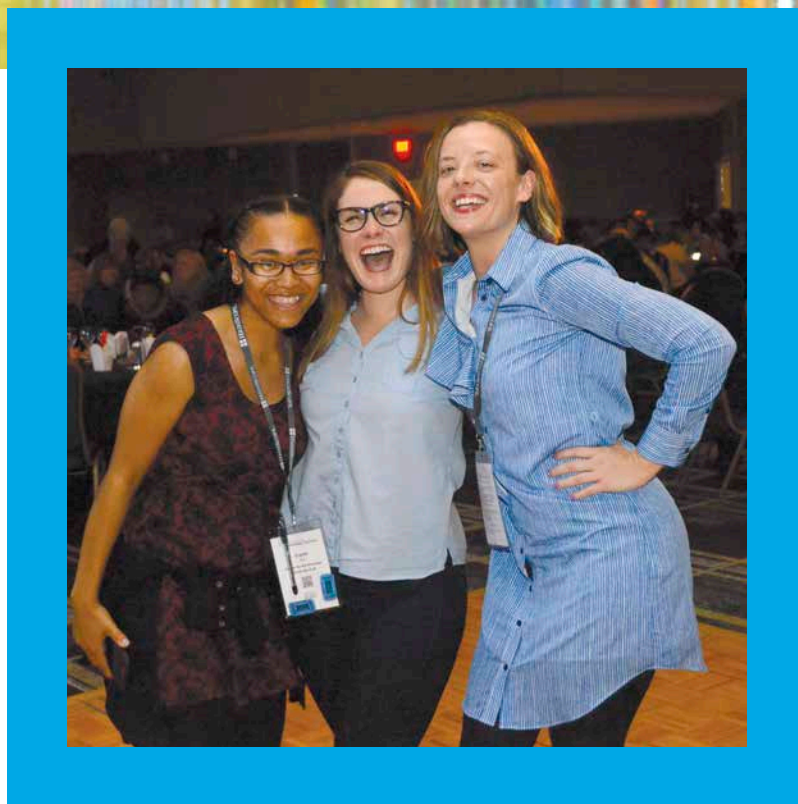
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Thanks to the combined efforts of HighScope Canada and HighScope Québec, many organizations that are part of Québec's child care services use the HighScope program in their own language – French.



Institute News

Québec (Canada)

BY MOYA FEWSON & DANIEL SAVARIA

With the *Ministère de la Famille du Québec* showing concern about educational approach and program quality in all child care services, the HighScope program has proven to be a promising avenue for teachers who take children's optimal development to heart.

Driven by this major uptick in interest, the *Association Québécoise HighScope* has been adding to its toolbox by developing activities and enlarging its pool of trainers. The Association's preparedness to seize this moment is the culmination of a process that began more than a decade ago, when Daniel Savaria, director of the bilingual child care services of Pointe-Saint-Charles Daycare, was concerned about discrepancies in the quality of its educational program. These concerns prompted him to request an assessment from the *Université de Montréal*. The conclusions of this assessment were very clear: The few English-speaking teachers with HighScope training in his child care service were the ones who were performing the best and providing better educational quality for the children. Daniel began by asking himself how he could enable all the teachers in his program to successfully establish these harmonious relationships with children.

His answer was to bring the HighScope Curriculum to Québec. The province of Québec is the only region in North

America where the majority of the population speaks French. As a linguistic minority on their continent, the Québécois have developed a public network of primarily francophone child care centres (CPE) that coexists with private day care centres and family child care services. The problem was clear: In order to be relevant in Québec, HighScope would need French language resources. At the time, it had none. Today, thanks to the combined efforts of HighScope Canada and HighScope Québec, many organizations that are part of the child care services use the HighScope program in their own language — French.

“HighScope Québec's tremendous success demonstrates the potential of the HighScope program even when a minority language community must first clear the way for a new language so that children can reap its benefits.”

To get where we are today took the close cooperation of a team of professionals dedicated to bringing HighScope to Québec. Daniel, a teacher with a natural entrepreneurship, conducted research over several months, and it was during this time that he first met Moya Fewson during one of her visits to Montreal, where she was conducting HighScope

training in English. Moya had served as a consultant and senior HighScope trainer for many years, playing an invaluable role in bringing the benefits of HighScope to Canada. Their meeting was the beginning of a positive story that is still developing and unfolding.

The first step was to make the HighScope trainings accessible to local talent. With Québec primarily providing child care in French, it was clear that trainings should also be conducted in French. In September 2007, francophone and HighScope expert Giselle Melanson travelled over 1,000 miles from New Brunswick to Montreal to ensure the success of the first preschool training with simultaneous translation in French.

That was only the beginning. Over the next few years, Daniel and France Cartier served as real-time translators of Moya's English-language training. These sessions became incredibly popular — so much so that Moya, rather than travel from her home in Markham, Ontario, was required to rent an apartment in Old Montreal in order to accommodate the demand.

Meanwhile, members of the Pointe-Saint-Charles and Trotinettes child care centres were so convinced of the quality of the HighScope program that, free of charge (yes, you read that right — free of charge), they translated the HighScope trainings

and documents, such as participant guides, PowerPoints, the PQAs, and even the COR.

A decade on and enthusiasm for HighScope trainings hasn't waned — on the contrary, it has grown. The trainings that Moya conducts in English are simultaneously translated into French. The unrelenting demand for training and official HighScope documents led to the unveiling, on May 19, 2011, of the *Association Québécoise HighScope* by its founders, Daniel Savaria, France Cartier, and Marielle Castonguay. The Association's mission is to offer HighScope certified training courses and resources for their French-speaking audience.

In 2013, the Association offered the first HighScope preschool training entirely in French to a group of francophone child care workers in northern Montreal. Four years later, Amélie Lambert offered the first infant-toddler training in French, and this year Marie Diane Trottier will give the full French training to a group of family child care teachers for the first time.



Moya Fewson is the executive director of HighScope Canada and senior consultant and senior trainer for HighScope Educational Research Foundation (USA). Here, at the first Conference HighScope Québec, Moya is conducting a master class for directors in the process of implementing the HighScope program as Marie-Diane Trottier, a Québécois certified trainer, translates.



Daniel Savaria is a HighScope Certified Trainer and co-founder and president of the Association Québécoise HighScope. At the first Conference HighScope Québec, Daniel is having a discussion with some of the participants.



France Cartier is a HighScope Certified Trainer, co-founder and vice-president of the Association Québécoise HighScope. Here, she is translating the music and movement workshop given by Janet Hutson-Brandbagen.



In 2015, the Centre de la Petite Enfance Mont-Royal became the first certified HighScope center in Québec.

During all these years, Moya remained a presence in Québec. She offered in-depth Training of Trainers (TOT) courses to certified teachers who wished to become HighScope educational consultants. Last year, Moya's cohort of trainers gave more than 500 days of training in French throughout Québec. Daniel himself has continued offering trainings throughout the province to this day.

A decade on and enthusiasm for HighScope trainings hasn't waned — on the contrary, it has grown.

In November 2016, Hélène Nadeau became CEO of HighScope Québec. She is responsible for managing all HighScope training and development projects in Québec and has seen her responsibilities grow as the exclusive highscopequebec.org website has developed to include subtitled HighScope video clips and several translations of the *Extensions* newsletter, among other resources. With the completion of the French translation

of COR Advantage accomplished, the Association plans to conquer the translation of the online tool next.

Perhaps the Association's proudest accomplishment has been the organization of the first HighScope Québec conference that took place in the spring of 2018. It was a smashing success. More than 250 members of the Québec HighScope community attended workshops given by Certified Trainers and HighScope educational consultants from Québec. Moya Fewson, Dr. Chris Maier, and HighScope field consultant Janet Hutson-Brandhagen led master classes and held specialized workshops for the enrichment of experienced teachers who carry out the HighScope program in its entirety.

HighScope Québec's tremendous success demonstrates the potential of the HighScope program even when a minority language community must first clear the way for a new language so that children can reap its benefits. At first

you need leaders, like Daniel and France, whose vision and close work with the HighScope Foundation forged a long-term commitment. Then, you keep offering ongoing training and mentoring — always, *always* searching for the highest HighScope quality, with the PQA as your guide. It takes time, of course, and the discipline to keep moving everyone toward the same goal. It takes tools, as well — like a website and other platforms for communication — and a lot of honest discussion about how things are going.

The *Association Québécoise HighScope* now has four Certified Trainers, with Amélie Lambert and Marie-Diane Trottier joining the two founders. It wasn't easy getting here — there were no shortcuts. It was patience and the dedication of a small team of tenacious professionals that carved out a space for HighScope in Québec. 🌱

Moya Fewson is the executive director of HighScope Canada. Daniel Savaria is president of the Association Québécoise HighScope.



Kaleidoscoop (The Netherlands)

BY MARCELLA FECTEAU WEINER

Since Kaleidoscoop first began providing training for early childhood educators in the Netherlands 23 years ago, it has focused on children and families at risk for educational disadvantage, most notably on those of low socioeconomic status. With a longstanding tradition of welcoming, and even embracing, immigrants from all over the world, and a recent influx of refugees from war-torn regions, the demographics of Dutch communities — and so also the children and families served by Kaleidoscoop — have changed, even as its educational approach has stayed the same.

Kaleidoscoop's small but highly motivated staff has supplemented this national policy by promoting HighScope as a high-quality early education program emphasizing active learning for all children in the Netherlands, whether they are native born, immigrants, or refugees. "No matter what their background is, active learning is a beautiful concept for all children, because it respects the autonomy and well-being of children and it supports their development," says Japke Schonewille, program leader at Kaleidoscoop. "We provide extra attention to language and cognitive development for children who are at risk for educational disadvantage," she adds.

For immigrant families, the home-school connection may serve as the most accessible conduit for their successful integration into the community. The HighScope daily routine, as well, serves as a stabilizing influence on many children and their families. As trainer/consultant Ellen van Eersel explains, "There is no better way for children to learn language and cognitive skills than from plan-do-review and small-group time. Children learn from

each other and the educators can interact and scaffold with the children and offer them gentle suggestions for further exploration."


The Netherlands has adopted a system that helps organizations to select and work with an effective early childhood program, called the Databank of Effective Youth Interventions. To become recognized in the Databank, programs must provide, every five years, the current evidence base supporting their curriculum. There are seven early childhood programs recognized in the Databank. Five of them have a sound theoretical basis, but only two programs, including Kaleidoscoop, are identified as "effective according to first indications." This means that there is research evidence that the program is effective and really helps children to close the gap caused by educational disadvantage.

“For immigrant families, the home-school connection may serve as the most accessible conduit for their successful integration into the community. The HighScope daily routine, as well, serves as a stabilizing influence on many children and their families.”

The "first indications" endorsement is an important qualification in the Netherlands because local governments often base their early childhood education policy on this recognition. The designation enables organizations and professionals to receive subsidized training — a vital condition for staff to implement Kaleidoscoop with high-quality standards. "Because of the half-open curriculum of Kaleidoscoop, in which professionals develop their own

plans and activities based on the interests of the children, professionals need time to grasp the essentials of active learning and to start to really enjoy working with it," says Djuna Denkers, staff consultant at Kaleidoscoop. "Most professionals get really motivated when they see how the children love to play with open materials, love to make their own choices, and love having control with the parts of the daily routine."

Impassioned about active learning, plan-do-review, group time, and scaffolding, Kaleidoscoop is eager to share its knowledge and expertise with early childhood teachers. In 2017, with a staff of 4 and a cadre of 25 trainers/consultants (partly freelance), Kaleidoscoop trained or recertified about 300 educators in 20 cities/regions (including Curaçao and Bonaire, two Dutch Caribbean islands) in the HighScope approach. "Twice a year we organize a day for our trainers/consultants to share ideas, recent developments, and new publications," says project leader Jolyn Berns. "Our latest publications are about the importance of play and scaffolding and we are preparing a publication about executive functions."

If the next two decades are anything like the first 23 years for Kaleidoscoop, expect to see a dedicated team of professionals tirelessly promoting high-quality early education anywhere that Dutch is spoken. "We are committed to provide equal opportunities to all children, and high-quality early childhood education is an important way to realize that ambition," notes Berns. 

Marcella Fecteau Weiner is a senior editor at HighScope.



The team of Kaleidoscoop enjoying a sunny day: [From left] Maureen van Benthem (project assistant), Japke Schonewille (program leader), Ellen van Eersel (trainer), Jolyn Berns (project leader), Nelleke Brandenburg (field consultant) and Djuna Denkers (staff consultant).



These are some of the HighScope resources Kaleidoscoop has recently produced.



Kaleidoscoop trainers present the new edition of Active Learning with Kaleidoscoop.

Early Intervention Professionals

What Does It Mean to Be Infant and Early Childhood Mental Health Informed?

BY ASHLEY MCCORMICK & FAITH EIDSON

ALLIANCE FOR THE ADVANCEMENT OF INFANT MENTAL HEALTH



Early education plays a critical role in recognizing and supporting the consistent, nurturing relationships that are integral to infant and early childhood mental health.

Perhaps when you hear the term infant and early childhood mental health (IECMH), you imagine a baby on a couch, with a Freud-like analyst asking, “How do you feel about that?” Although a funny image, that’s not what the term actually means.

We hold two primary ways of thinking about and understanding IECMH. The first way is to consider the definition: “The developing capacity of the child from birth to five years of age to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn — all in the context of family, community, and culture” (ZERO TO THREE, 2016, para. 1). With this in mind, IECMH is easily understood as support at an especially critical period for infants and young children. During the first years of life, children are building, in relationship with their primary caregivers, their internal framework for emotion regulation, interpersonal relationships, and exploration (ZERO TO THREE, 2016, para. 2). It is upon and within this framework that all future experiences, most notably relationships, are built. If we want children to have the very best beginning, or framework, we must, through a positive understanding of IECMH, support the crucial caregiving relationships around them.

Another way to think about the term IECMH is to consider the practice of it. The practice of IECMH includes a broad range of work with or on behalf of infants, young children and their families, across the full continuum of promotion, prevention, intervention, and leadership (ZERO TO THREE, 2016). The IECMH workforce may find itself promoting optimal social-emotional development and relational health; working to prevent disorders of infancy and early childhood (including relational disorders); intervening when IECMH disorders exist or when a parent’s mental or behavioral disorder affects their relationship with the young child; and promoting policy, practice, and research at macro levels. In this article we are going to hold in mind both ways of thinking about and



Within the context of relationships with adults, infants learn to watch, listen, respond, and organize their behaviors — playing an active role in their own development.

defining the term IECMH, as we believe both are essential to understanding and supporting infants, young children, families, and all those who care for them.

ORIGINS

The field of IECMH is interdisciplinary and has been informed and supported by many important bodies of research, theory, and practice. It is our belief that all professionals who touch the lives of infants, young children, and families should be informed and supported in their knowledge of the key areas of attachment theory, human development, and attention to equity and culture.

The origins of attachment theory can be traced back to John Bowlby. Bowlby was commissioned by the World Health Organization (WHO) to report on the mental health of homeless children in post-war Europe in 1949 (Bretherton, 1992). In 1951, he published *Maternal Care and Mental Health*, in which he wrote, “the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment” (Bowlby, 1951, p. 11). Ultimately, this led to the development of *attachment theory*. Attachment theory suggests that attachment is a biological strategy to help assure the survival of the very dependent infant through the proximity and protection of an available, willing adult (Bowlby, 1988).

It is not uncommon, when considering attachment, to think of the baby’s perspective alone. However, Donald Winnicott reminds us that the child’s point of view is only half of the equation when he says, “There is no such thing as a baby...If you set out to describe a baby, you will find you are describing a baby and someone” (Winnicott, 1978, p. 88). Additionally, the contexts of culture, race, and equity are critical to our understanding of attachment. The hope is that the “someone” to whom Winnicott refers is a willing adult who can offer a loving, responsive, and consistent relationship to the infant, within the context of the infant’s own family, community, and culture.

“All professionals who touch the lives of infants, young children, and families should be informed and supported in their knowledge of the key areas of attachment theory, human development, and attention to equity and culture.”

Infant and early childhood development, including social-emotional development, often occurs in predictable, sequential stages that can be observed and supported (Bradley Early Childhood Clinical Research Center [BECCRC], 2015; Davies, 2011). This development happens in the context of relationships. The developmental trajectory of a young child is largely dependent

Feature

upon their social relationships and environment (BECCRC, 2015; Davies, 2011). The relationship between the primary caregiver and young child is reciprocal and ever evolving in parallel with the child's own development (Weatherston & Tableman, 2015). Knowing this, it is critical for primary caregivers to be safe, consistent, and reliable nurturing partners in the developmental process. Just as important, the young child plays a very active role in their own development. This is because within the ongoing and developing relationship, the infant learns how to watch, listen, respond, organize behavior, control and contain responses, and express feelings and needs.

By being sensitive to cues, holding a stance of acceptance, and being physically and emotionally available, caregivers send the message to young children that they are safe and that all parts of them are seen and valued, including their race and culture. For early care educators, cultural responsiveness is critical to sensitive and responsive caregiving. This means understanding the family, culture, and community of the young children with whom they work. Early care educators can provide learning opportunities, experiences, and an environment that represent the cultures and communities of the children in their classroom.

GROWING INTEREST IN INFANT AND EARLY CHILDHOOD MENTAL HEALTH

Increasingly, in our own work with early childhood educators, we have heard reports of more children in classrooms who have been affected by trauma, who struggle with regulation of their emotion and behavior, and who are faced with multiple risk factors in their homes and communities. Research tells us that preschool expulsion rates are more than three times those of students in kindergarten through 12th grade (Gilliam, 2005) and that the expulsion rate of African-American boys is especially disproportionate (Gilliam, 2016). While the leading reasons for these expulsions are "disciplinary" or "behavior" concerns, the underlying causes may be overlooked or misunderstood (Gilliam, 2005). How can a young child learn if he does not have enough food to eat? How, for example, might we see the "behavior" of a toddler who won't remain seated at circle time as a result of her fear and hypervigilance upon witnessing her mother and father physically fighting every night? How can a preschooler listen to her teacher if her previous experiences with adults have led her to believe that adults are not to be trusted? These challenges have led the early childhood education field to begin to apply IECMH principles and



The Michigan Association for Infant Mental Health (MI-AIMH) identified the core competencies required of any professional who works with babies and helped to develop a system of workforce development, known as Endorsement, to promote these competencies in practice.

components as a lens through which to better understand and inform their work. Given that the relational and social-emotional health of infants and young children is the foundation for all learning, it is clear why early childhood educators want to support the mental health of the very young children in their care.

One of the core principles that is especially relevant to early childhood educators is the belief that “behavior has meaning” (Brazelton, 1994). IECMH promotes the understanding that a young child’s behavior, rooted in development, is reflective of his or her emotional experience and well-being. When viewed through this lens, behavior that seems difficult and frustrating can instead become an opportunity to listen closely and to attempt to understand the young child’s experience. This closer look may provide a clearer answer to the question of what a child needs from the caregiver, leading to more effective intervention.

Yet another principle and core understanding of IECMH is that relationships can be healing, particularly relationships with a consistent, predictable, and kind adult. Researchers who study the brain have discovered that a young child cannot engage the parts of his brain needed for learning the alphabet if he does not feel safe (National Scientific Council on the Developing Child, 2005/2014). The accumulating neuroscience indicates that the calming and reliable presence of caring adults is the most important factor in supporting learning for the young children in their care.

REFLECTIVE SUPERVISION/CONSULTATION

As the early care and education field has become more IECMH informed, it has begun to embrace *reflective supervision/consultation* (RS/C), a core component of IECMH work, as a way to support all professionals in their understanding and application of IECMH principles. The experience of RS/C over time and with a reliable reflective supervisor offers professionals the opportunity to engage in a safe, reliable, and consistent learning relationship (Fenichel, 1992). In our reflective support of early education providers, we have learned that many feel unprepared and unequipped to meet the needs of some of the young children in their classrooms. Sometimes, this can lead to feelings of powerlessness and exasperation, which inevitably is felt by the young children in their care.

“The accumulating neuroscience indicates that the calming and reliable presence of caring adults is the most important factor in supporting learning for the young children in their care.”

Within a reflective supervisory relationship, early educators are invited to slow down, to explore their experiences with a particular young child or parent, and to ponder their emotional responses to them. Rebecca Shahmoon Shanok (1992) describes reflective supervision this way: “When it’s going well, supervision is a holding environment, a place to feel secure enough to expose

insecurities, mistakes, questions and differences.” Those questions and differences can include wondering about one’s own personal biases about race and culture and how they impact one’s way of interacting with a young child or family. In the context of a safe relationship, early care educators are engaging in a parallel process that can be applied to the young children in their care.

Within the context of this reflective relationship, early educators learn more about the importance of attachment relationships, the effects of trauma on young children, and how to apply that knowledge to their work. While teachers are not and should not feel pressured to be mental health providers, they can benefit from reflecting on and learning about the factors that affect mental health in infants and young children. Deeper understanding of those core concepts can lead to a greater sense of empathy for the young children and families that they work with. Perhaps most powerfully, early educators learn or are reaffirmed in their belief that the most important vehicle for change for a young child in their care is the nurturing relationship that they themselves offer. When educators view young children through the lens of relationship, while simultaneously experiencing a reflective learning relationship through RS/C, they are better able to support the young children in their care (Howes et al., 2003).

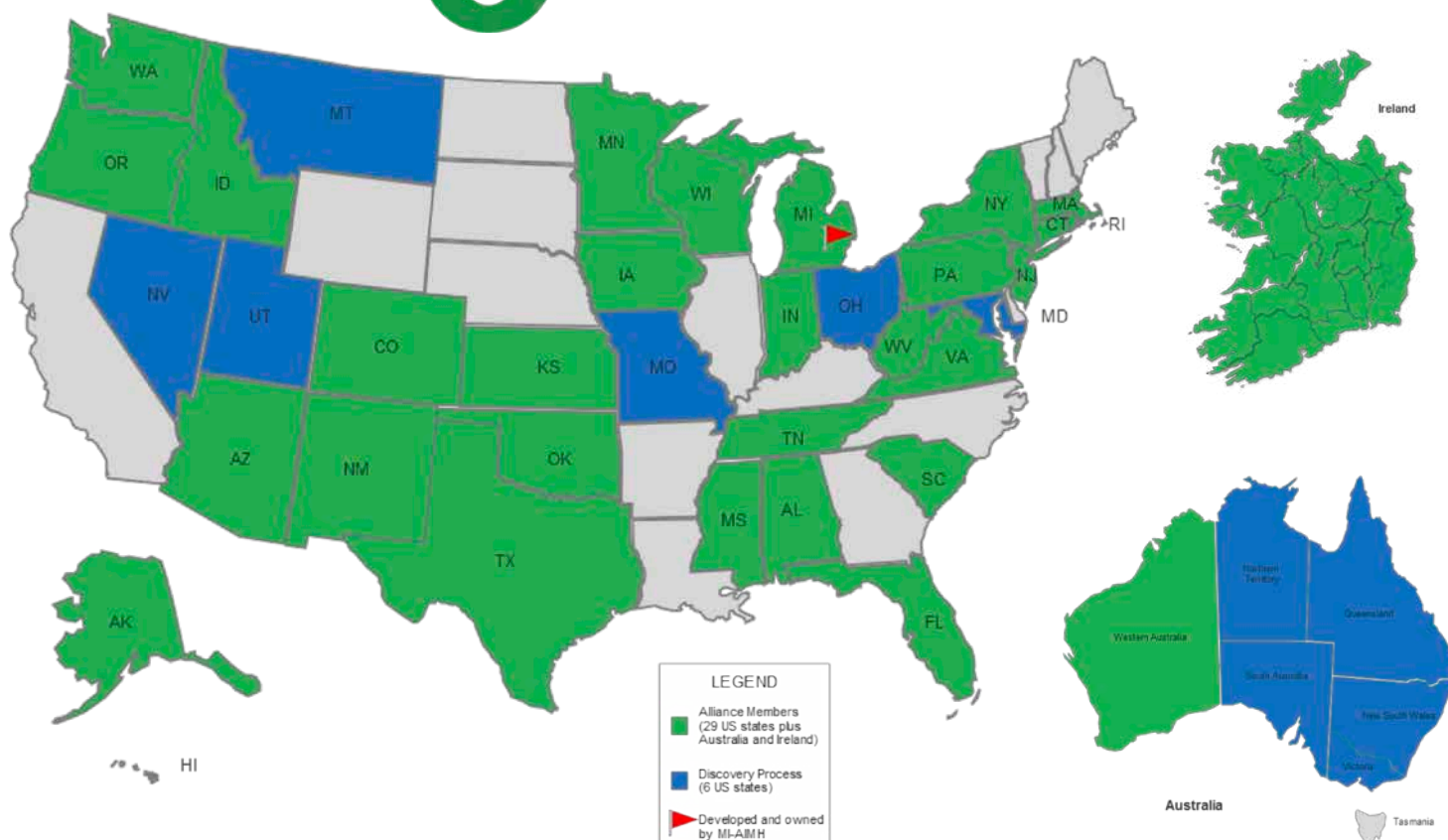
Early education systems and organizations can benefit from an IECMH-informed workforce. When staff feel knowledgeable, prepared, and supported through RS/C, they are more competent and effective. In an evaluation of the impact of RS/C on a group of Early Childhood Special Education (ECSE) teachers, Harrison and colleagues (2016) found that the teachers reported improvements in their ability to shift perspective, to address personal biases, to set boundaries, slow down, observe, and listen. Of additional importance, the teachers described feeling heard, validated, and affirmed in their work, and reported feeling more effective in their ability to assess, focus, and respond to the young children with developmental delays and disabilities (Harrison, 2016).

MICHIGAN’S STRONG ROOTS

During the mid-1980s, federal legislation was passed requiring family-centered services for infants and toddlers with delays and/or disabilities. In Michigan, the Department of Education (MDE) led the implementation of these services and identified several areas of competency for early intervention professionals. The Michigan Association for Infant Mental Health (MI-AIMH), a non-profit whose mission is to promote and support nurturing relationships for all infants, very young children, and their families, was asked to assist in the process of identifying these competencies. In 1997, MI-AIMH assembled an interdisciplinary committee of volunteers to build upon the MDE competency domains and identify core competency areas for “any professional who touched the life of a baby.” In 2000, MI-AIMH received funding from W.K. Kellogg Foundation to hire an executive director, complete the



Alliance for the Advancement of Infant Mental Health



identification of core competencies — now referred to as the *Competency Guidelines*® — and create a systematic plan for workforce development now known as the Endorsement for Culturally Sensitive, Relationship-focused Practice Promoting Infant and Early Childhood Mental Health® (Endorsement®), which was finalized in 2002.

Endorsement is an internationally recognized credential for professionals working with or on behalf of infants, young children, and their families. Endorsement is a verifiable process that is based on the *Competency Guidelines*, which recognize specialized training, acquired knowledge, RS/C, and work experiences for all professionals in the IECMH field.

Shortly after its launch, Endorsement became recognized as a workforce development tool to support and improve the practice for infant, young child, and family professionals. Infant mental health associations across the world began to approach MI-AIMH to inquire about the use of Endorsement in their regions, and by 2013, 13 state associations had licensed the MI-AIMH materials. Due to the oversight and quality assurance demands of these materials, the MI-AIMH board of directors and leaders in other member associations recognized the need for organiza-

tional change. In response, they created a new organization: The Alliance for the Advancement of Infant Mental Health. The Alliance is a global organization that includes those states and countries whose infant mental health associations have licensed the use of the workforce development tools, *Competency Guidelines*, and Endorsement. The Alliance manages the licensing and quality assurance of Endorsement across all member associations. MI-AIMH retains the copyright for the materials. There are currently 29 US states and two countries that have licensed the use of the *Competency Guidelines* and Endorsement (see graphic).

“Endorsement is an internationally recognized credential for professionals working with or on behalf of infants, young children, and their families....”

Endorsement offers multiple pathways for professionals working with or on behalf of infants, young children, and families. It recognizes the participation in experiences that lead to competence in IECMH principles and practices and it acknowledges a professional's choice to specialize in IECMH. As early childhood educators and systems integrate key IECMH concepts into work with infants, young children, and families, some are considering




Endorsement is seen as a rapidly expanding strategy to ensure the competence of the early childhood workforce.

Endorsement a key strategy to ensure competence and quality across the workforce. Endorsement offers educators the opportunity to document their knowledge and skills as they relate to working with infants, young children, and families. ZERO TO THREE has developed Critical Competencies for Infant-Toddler Educators (2016), in which they identify competencies that complement and have been crosswalked to the MI-AIMH competencies that serve as the foundation for Endorsement. As employers come to learn the benefits of having IECMH-informed early childhood educators, some now recommend or even require it for their employees.

A LOOK TO THE FUTURE

As the early care and education field continues to adopt core IECMH principles and competencies, a stronger foundation is built for all infants, young children, and their families. If we understand that the promotion of IECMH with attention to race, culture, and equity is the key to optimal development and readiness to learn, and if we agree that consistent and nurturing relationships are the primary vehicle for physical and relational health in young children, then it becomes clear that the early childhood education system is a critical partner in strengthening IECMH.

For a list of references used in this article, please see the online version of this issue of The Active Learner at HighScope.org. 

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The Importance of Mental Health Screening

BY OSCAR BARBARIN



Mental health screening tools use reporting from families, teachers, and caregivers to identify behavioral concerns and differentiate between those that are likely to be temporary, and those that warrant follow-up with a mental health professional.

Getting off to a good start in early childhood programs is critical to children's long-term success in school. For some children, the transition to school goes fairly smoothly, with minor adjustment issues along the way; for others, the path to academic success presents more challenges, socially and emotionally. Early problems of adjustment, if not addressed, can be a significant impediment to later academic achievement. Early education, then, includes identifying and addressing children's early socioemotional difficulties as among its most important goals.

Head Start and some state early education programs have promulgated standards that require processes for identifying and serving the needs of children who exhibit early socioemotional difficulties in such areas as self-regulation of attention, behavior, and emotions. Children, of course, run the gamut from socially and emotionally adept to impulsive and emotionally troubled. Program staff may have little trouble identifying children at the extremes of social-emotional competence, but encounter difficulty differentiating the vast numbers in the middle of that continuum.

Often preschool educators struggle to discern the difference between children's temporary or transitional difficulties that will resolve in time as the child matures, and problem behavior that is predictive of severe difficulties ahead. Staff may observe a problem or have concern about some aspect of a child's behavior but may be uncertain about whether the behavior warrants special attention and follow-up. This uncertainty may lead to a failure to take action that might ameliorate the situation or prevent more serious long-term difficulties as the child gets older. Furthermore, while few early childhood staff need to be convinced of the importance of early intervention, some may be reluctant to assign a label to a child's behavior for fear that label may "stick" even after the issue is resolved.

Caregivers are understandably puzzled. Should they be patient and give the child the chance to self-correct, or must they develop an intensive intervention before a perceived problem escalates? Is the concern related to a temporary behavioral issue or is it a deeper, more systemic problem that may lead to major long-term challenges? Rarely are these questions resolved with complete confidence.

“Program staff may have little trouble identifying children at the extremes of social-emotional competence, but encounter difficulty differentiating the vast numbers in the middle of that continuum.”

MENTAL HEALTH SCREENING TOOLS CAN HELP

Parents and teachers can benefit by using a comprehensive mental health screening tool. As these tools become more prevalent, their makeup varies, but generally, a mental health screening tool is a simple self-report instrument completed by program staff and parents in which they identify aspects of child behavior that cause concern and respond to questions that can be used to judge the severity of those concerns. A developmentally appropriate screening tool can be used by persons with limited training in mental health, and while not used for diagnostic purposes, screening tools summarize information that is essential for behavioral consultants and health professionals who may ultimately make a decision on intervention. A useful and comprehensive tool addresses the adjustment issues most commonly identified by early childhood staff and is developed and designed in consultation with early childhood programs.

A mental health screening provides a low-intensity approach that compares the child to a reference group and, on that objective basis, concludes whether the behavior is unusual or extraordinary enough to require some follow-up action or intervention. The screening is not intended to be used alone as an end unto itself, but is instead most effective when it is incorporated into a multilevel system of mental health care and intervention. Once the screening is completed, the work of follow-up and intervention begins and appropriate intervention is provided at multiple levels: the program, the classroom, and the child

and family. An effective system of mental health care utilizes screening, early intervention, and prevention.

Beginning with universal screening of mental health concerns early in the school year, the system analyzes prevalence data to identify patterns of child problems across regions of services, programs, and classrooms, providing follow-up services such as

- Changes in the classroom structure, procedures, or rules
- An intervention by program staff focused on the specific needs of the targeted child
- A formal request for observation and feedback from a behavioral or health consultant
- Referral to services outside of the early childhood program

Finally, it links analysis of screening results to staff training, staff support, and allocation of individually focused mental health resources.

Mental health screenings can help program staff and parents use objective criteria and apply them consistently across children and settings to make the critical decisions about whether a child's problem or concern is something that is normative, something they should try to change through their normal practices, or something that requires consultation and assistance from a mental health or learning specialist. In addition to its use by staff on an individual basis with children, a mental health screening tool can be most useful

Mental health screenings are not intended as stand-alone diagnostic instruments. Although the issues they assess are related to psychological disorders defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) — the diagnostic tool published by the American Psychiatric Association — screening tools do not provide conclusive evidence to make a definitive diagnosis. Thus, even if a child is screened as having a severe problem, this does not mean that the child meets the criteria for a DSM-based diagnosis. Making a diagnosis requires the judgment of a trained and experienced professional who employs multiple methods for assessing children, including direct observation of interactions with adults and peers as well as interviews of program staff and primary caregivers at home.

as part of a system of universal screening that programs adopt for planning purposes and for the design of preventive interventions. 

Oscar A. Barbarin is a professor of psychology and African-American Studies at the University of Maryland. He chairs the African-American Studies program and conducts research on mental health services for young children.

Music Throughout the Daily Routine

BY ERICA HILL

Not every early childhood educator considers themselves a “musician,” and some may struggle to carry a tune. You don’t have to be an expert to know that children’s natural development of musical qualities is enhanced with the help of adults who allow them to explore and experience sound through singing, moving, listening, and playing instruments.

Music and movement can be used throughout the daily routine to help children develop gross-motor skills, self-regulation, and executive function.

1. WORK TIME (CHOICE TIME OR FREE TIME)

Children may choose to create a series of movements, demonstrate a dance, or sing words to a particular track on their own. (Note: Music should not be used as background music; however, the teacher can play music during work time in response to a child’s choice to listen to music.)

2. SMALL-GROUP TIME


Ask children to think and talk about a music selection, and invite them to share their feelings or thoughts in response to the music. Then have them draw how they feel or think.

Have children use art materials while they’re listening to music. For example, have children paint while listening to fast and slow songs and compare how they paint when listening to music of different tempos.

3. CLEANUP TIME

Ask children to clean up while the music is playing and then freeze when the music stops. Repeat cleaning/stopping for the whole song and see how many times it takes to clean/stop before cleanup is finished.

4. LARGE-GROUP TIME

During large-group times, encourage children to listen to a musical selection and move their bodies to the way it makes them feel. By listening to the music, thinking of and describing how they want to move, and then following through, children are developing their self-regulation skills and their ability to stop, think, and act. 

Erica Hill is an early childhood consultant at HighScope.



How can you support children's movement skills during large-group times?

Children take great pleasure in expressing themselves through creative movement. The ability to do this is strengthened when adults intentionally model new actions and gestures for children to imitate. Planning large-group activities around a musical selection allows children the opportunity to express themselves creatively through movement, giving them confidence in their ability to communicate with their bodies.

You support children's movement skills when you imitate, acknowledge, and label their movements; ask for their ideas and clarify their choices about how to move; connect their movements to aspects of the music; and choose a material — such as instruments, fabric, shakers, or a parachute — for children to move with as they listen to the music.

How can you support children's executive function and self-regulation skills during large-group times?

Executive function is what allows us to process sensory inputs as we focus on what's relevant, make decisions about that information, make plans, and revise those plans. As children are given choices of what to sing, how to move, and ways to respond during large-group time, they need to regulate their behaviors to participate in the activities, thereby practicing and developing executive function skills.

You support children's self-regulation and executive function when you encourage them to move to the tempo of the music (or opposite the tempo, e.g., move slowly to a fast song); alternate between moving to the music and stopping; move their bodies in response to soft or loud music; and move to a specific instrument.

Learn more about large-group times by enrolling in the Large-Group Times for Active Learners online course. See page 37 for more details!



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"I've learned more than I expected and feel confident that I'll return to my classroom with a new approach that will benefit my students."

A great classroom is laughter-filled, engaging, and packed with rich learning experiences at every turn. So is great professional learning.

At HighScope, we believe that educators deserve the same level of engagement and inspiration that they provide their children every day. That's why our professional learning program features the best of adult learning through active engagement, collaboration, and reflection.

Courses are designed to respond to participants' individual strengths and focus on practical application and implementation in real world settings. We work to ensure every experience offers inspiring ideas and strategies that can be immediately applied in the classroom.

**Take a closer look at
HighScope's Professional Learning.**

2019 Online Courses

CREATING MEANINGFUL PRESCHOOL LESSON PLANS

Learn strategies to plan appropriate activities for each segment of the daily routine based on curriculum content, developmental needs, and children's interests.

INTENTIONAL LESSON PLANNING FOR INFANTS AND TODDLERS

Learn to develop lesson plans based on curriculum content as well as children's development and interests. You'll return to the classroom with your own lesson plan, plus the skills and confidence to intentionally plan for infants and toddlers, scaffold learning, and include families in the planning process.

HOW TO SUPPORT ACTIVE LEARNING AT WORK TIME

Learn how to put the "active" in active learning! Includes the four types of play children engage in during work time and strategies for supporting and scaffolding children's development.

ALL ABOUT NUMBERS PLUS

Explore important math concepts for preschoolers — geometry, measurement, data analysis, and more. Learn which materials you can add to your classroom to support math learning and how to scaffold learning using specific interaction strategies.

COR ADVANTAGE

Successfully identify the categories, items, and indicators of HighScope's child assessment instrument, COR Advantage. Through expert instruction and video clips, you will learn how to collect and accurately score objective evidence and receive strategies to engage families in the child assessment process. Includes reliability test.

PROGRAM QUALITY ASSESSMENT (PQA)

Gain hands-on experience in observing, recording, and evaluating program quality using HighScope's program quality assessment tool. Available for infant-toddler and preschool programs. Includes reliability test.

PQA RELIABILITY TEST

Certify that you are a reliable PQA Assessor with this test — available for infant-toddler and preschool programs.

SMALL-GROUP TIMES FOR ACTIVE LEARNERS

Explore how children discover content through active learning during small-group times. This course offers many new activity ideas, as well as methods for planning the three components of small-group time and scaffolding to maximize each child's learning experience.

LARGE-GROUP TIMES FOR ACTIVE LEARNERS

Learn how to develop large-group activities and plans that bring children and adults together for songs, games, projects, activities, and storytelling.

PLANNING AND RECALL: WHY AND HOW

Learn how to create planning and recall experiences based on children's interests and developmental needs. Explore the benefits of planning time and recall time, the similarities and differences, and how these integral processes change as the school year progresses.

For full course descriptions and to register, visit [HighScope.org](https://www.highscope.org)

The content **you need most** — *tailored* for your development.

Effective Training.

Courses are designed to provide thorough training for teams at all levels and focus on evidence-based practices that compliment any developmentally appropriate curriculum. Whether you're looking to deepen your understanding or extend implementation — we'll work with you to find the "just right" fit to help you reach your professional learning goals. Call us to create your individualized learning experience!

Bring a HighScope Trainer to you!

Our instructors have a deep background in early education, with ample classroom experience to provide expert guidance to your team. All courses can be held on site at your school or program.

Quality Coaching.

Our coaching model emphasizes growth and learning through unmatched one-on-one support. Working together, the teacher and coach build a trusted, collaborative partnership that enhances instruction and ensures students learn at the highest levels. Coaching provides countless opportunities for the teacher and coach to gain insight, reflect, and grow. We can also work to develop your skills so you can coach others!

REGISTER
today!

Alphabet Dance

BY HIGHSOPE EARLY CHILDHOOD APPLIED PRACTICE



Try this literacy activity using HighScope's newest collection of instrumental music, *Big Beats for Young Peeps*, available now at [HighScope.org](https://www.highscope.org).

Large-group time: Children dance and move to music around alphabet cards the teacher has placed on the floor; when the music is turned off, children stop on one of the cards.

Literacy Focus: Alphabet knowledge: Children identify and recognize letters of the alphabet.

MATERIALS:

- Letter cards (recommended 8 ½" x 11" cardstock); there should be an uppercase letter card for the first letter of each child's and adult's name. (If children's names begin with the same letter, make multiples of that letter so that every adult and child has a letter card.)
- Instrumental music

BEGINNING

- Spread out the letter cards in the large-group area.
- Introduce the activity to the children. You might say, *Today we are going to do an alphabet dance. When the music is playing, we will dance. When the music stops, we will quickly find a letter to stand on.*

MIDDLE

- Turn on the music and dance with the children. After a few seconds, stop the music. Encourage children to stand on a letter.
- When everyone is standing on a letter, look down at the letter you are standing on and make a comment about it. You might name the letter or mention that it is a letter in a child's name (e.g., *I'm standing on the letter L. Hey, Louis, that's the first letter in your name*).
- Invite children to say something about the letters they are standing on. You might say, *Take a look at the letter you are standing on and the letters around you. What letters do you see?*
- Give children a moment to talk together about the letters they see. Acknowledge what they say by repeating their words (e.g., *Nya says she is standing on her letter N*). You might ask if anyone else is standing on the first letter of their name or add additional information about a letter (e.g., *Carter is standing on the letter that makes the /t/ sound*).
- Tell the children that you are going to play the music again. Encourage children to find a different letter to stand on when the music stops. When children have had the opportunity to share about their letters again, turn the music back on and repeat the game.

[Note: The goal is to encourage children to talk about the letters without testing them on letter names and sounds. Some children will be very excited to name and talk about the letters they are standing on. Other children may simply look at letters without commenting. Support these children by talking about the letters they are standing on (e.g., *Olive you're standing on the D. That's the first letter in Dustin's name*).]

END

- Let children know when you come to the last round of the game.
- To transition to the next activity, call out the names of the letters children are standing on. Ask them to move to the next part of the routine when they hear the name of the letter they are standing on. 🎵

Building Policy Credibility

Using Your Voice to Link Policy With the Realities of the Classroom

BY JANA MARTELLA, CENTER ON ENHANCING EARLY LEARNING OUTCOMES
BRYAN STOKES, ILLINOIS ACTION FOR CHILDREN

As early learning professionals, we know the importance of early investment in high-quality early childhood development. Research in brain development has demonstrated that critical neural connections develop rapidly in the first few years of life, setting a foundation for future success. In addition, economist Dr. James Heckman's work has made clear the immense return on investment in high-quality education for young children — 7 to 10% annually in improved societal outcomes.

States have responded to this new awareness with steady increases in funding for our youngest learners. Unfortunately, as highlighted in the 2017 NIEER Yearbook, per pupil early childhood funding fell nationally for the first time ever in 2017 and, despite the new investments, programs are only reaching 33% of four-year-olds nationally and 5% of three-year-olds. Progress nationally continues to be slow and uneven — and issues of quality, access, and equity demand new solutions.

The voices of early learning professionals — teachers, directors, coaches and others — are critical to advocating for new resources and ensuring that policy decisions are informed by the realities of the classroom. In particular, legislators and early childhood policy advocates need to hear your stories — both challenges and successes. What innovative practices has your program adopted that could be replicated? How have you improved access to your program for children with multiple risk factors? What policy barriers stand in the way of your success?

Not only do your stories make the impact of high-quality early learning programs more evident, but they also help to



A functioning early childhood system requires the advocacy of the people who know children best — the families and educators who interact with them every day.


articulate that early learning programs are only one component of a functioning early childhood system — one which prepares children for success in school and life. Access to health systems and family leadership and support are equally critical. As we know, children living in families without adequate housing face barriers to success that require additional resources for educators and cannot be solved solely in the classroom or through home visiting. Absent this context, it is only possible for legislators to consider investments in early childhood program capacity — without investments in comprehensive supports for families, and with expectation of the same outcomes.

The voices of early learning professionals — teachers, directors, coaches, and others — are critical to advocating for new resources and ensuring that policy decisions are informed by the realities of the classroom.

Policy and funding decisions at the local, state, and national level fundamentally impact your program and the children

and families that you serve. To make sure that your voice is represented in these decisions, consider the following steps:

- **Identify existing advocates:** Are there already policy and advocacy groups working on your issue? Many advocacy groups are membership organizations and will be happy to add you to their mailing list for policy updates. In addition, they are eager to hear your stories. Reach out and find out how you can become involved.
- **Define the issue:** If you have already identified a policy barrier that is preventing you from being successful, identify the source. Is there a written policy or statute that addresses this issue? If so, who is responsible for changing it? Be wary of myths that sometimes spread within or between programs about requirements or barriers that don't exist.
- **Build your narrative:** Consider the stories that you can share from your experience to connect policymakers to your issue. Has your program successfully implemented mental health consultation to support teachers in meeting the social-emotional needs of children? As states move toward bans on suspension and expulsion — and consider the supports needed to reach that goal — your story would be highly informative to policymakers.

Consider your expertise. Who better to advocate for early childhood education policy than you? Your investment in children and families recommends a prominent seat at the table for you and all early educators in the policy discussions about the work you do every day. How will you make your voice heard? 



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Join us next year when we return to the Detroit Marriott at the Renaissance Center. This inspiring conference is sure to empower you to help our youngest learners succeed.

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REGISTRATION OPENS **January 2019**

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