

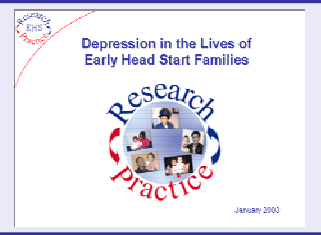
# Early Head Start Research and Evaluation Project



**TALKING POINTS:  
"DEPRESSION IN THE LIVES OF EARLY  
HEAD START FAMILIES"**



# SLIDE 1: Depression in the Lives of Early Head Start Families



*[Notes to the presenter: you may want to add a few slides from the Overall Findings PowerPoint presentation to provide background on the Early Head Start program or the Early Head Start Research and Evaluation Project.]*

Introduction: This presentation includes findings from the recently completed Early Head Start Research and Evaluation Project that focus on the role of depression in the lives of Early Head Start families.



## SLIDE 2: Why Study Depression?



**Why Study Depression**

- Depression is common for low-income families and is associated with poor child outcomes
- Head Start Program Performance Standards
  - Mental health consultant
  - Timely and responsive services
  - Family-centered mental health services and education

It is important to study depression in Early Head Start families because the population served, low-income families, are at risk for stress and depression. Parental depression has also been linked to poorer child functioning, especially when children are young. So, it is important to understand that many families may be experiencing the distress associated with depression. It is also important to examine the role of Early Head Start in preventing depression, preventing the consequences of depression for families who are experiencing problems, and linking families with needed mental health services.

While depression is perhaps the most common mental illness, it is important to note that it often occurs in the context of other problems, and is often the result or side effect of other problems. Some Early Head Start families also experience mental health issues such as post-traumatic stress disorder, anxiety, and substance use.

As a comprehensive child development program, Head Start has long been concerned with supporting the social and emotional well-being of children and families and with providing and/or accessing services for those families with mental health needs. In fact, the Head Start Program Performance Standards require each program to obtain a mental health consultant (1304.52), as well as timely and responsive services (1304.24) and family-centered mental health services and education (1304.40).

## ADDITIONAL INFORMATION

Many in the Head Start community, both parents and staff, are struggling to understand and address the mental health needs of very young children. It has been a particular challenge for Head Start programs serving infants and toddlers, as there are relatively few resources available to meet the needs of our youngest children. In order to support programs in this work, in October 2000, the Head Start Bureau convened a national meeting of experts in the field, including Early Head Start staff, parents, experts from the multiple clinical and research fields whose work relates to infant mental health, along with other federal partners and interested stakeholders. The report from that meeting details rationale for studying infant mental health, principles to guide work, and suggested action steps for the Head Start Bureau.

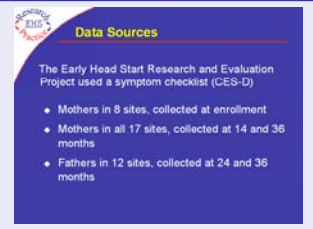
As an outcome of that meeting, the Administration on Children, Youth and Families (ACYF) has funded the Early Head Start National Resource Center at Zero to Three to engage in training and technical assistance activities designed to raise awareness and create and disseminate resources for programs (see <http://www.ehsnrc.org>). In addition, ACYF has funded the Early Promotion and Intervention Research Consortium to develop and test approaches that support the mental health of infants and toddlers and their families in Early Head Start (see the following URL:

[http://www.acf.hhs.gov/programs/core/ongoing\\_research/epirc/epirc\\_intro.html](http://www.acf.hhs.gov/programs/core/ongoing_research/epirc/epirc_intro.html))

### DISCUSSION QUESTIONS:

- ◆ Does your staff feel prepared to work with families suffering from mental illness?
- ◆ What resources do staff have to draw on? Mental health consultant? Sources for referrals? Supervision? Training opportunities?
- ◆ What relationships do you have with community mental health agencies?

## SLIDE 3: Data Sources



**Data Sources**

The Early Head Start Research and Evaluation Project used a symptom checklist (CES-D)

- Mothers in 8 sites, collected at enrollment
- Mothers in all 17 sites, collected at 14 and 36 months
- Fathers in 12 sites, collected at 24 and 36 months

The Early Head Start Research and Evaluation Project collected information on maternal and paternal depression. I will talk today about information collected using the Center for Epidemiologic Studies–Depression Scale (CES-D), a checklist of depressive symptoms, with well-established cutoff scores for probable depression.

- ◆ In 8 of the 17 research sites, mothers completed the CES-D at the time of enrollment into the research.
- ◆ Mothers in all 17 of the research sites completed ratings of depressive symptoms using the CES-D when their child was 14 and 36 months old and information on service use by 28 months after enrollment.
- ◆ Additionally, fathers in 12 of the 17 sites completed the CES-D when their child was 24 and 36 months old.

## ADDITIONAL INFORMATION

There are 2 main ways of measuring depression:

1. Symptom checklists have cutoff score indicating levels of risk for depression. Symptom checklists allow you to track how symptoms change over time and are also useful for determining when to refer to a specialist for additional assessment, diagnosis, and possible intervention.
2. Diagnostic interviews use more stringent criteria for meeting diagnosis and require more training to administer and interpret, because interviewers actually determine diagnoses.

### Examples of Checklists:

The Center for Epidemiologic Studies Depression Scale (CES-D)--Radloff, L.S. (1977). The CES-D Scale: A Self-Report Depression Scale for Research in the General Population. *Applied Psychological Measurement*, 1, 385-401.

- ◆ A copy of the scale is available at:  
<http://www.mhhe.com/hper/health/personalhealth/labs/Stress/activ2-2.html>

Beck Depression Inventory--Beck, A.T., Steer, R.A., & Garbin, M.G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review* 8 (1), 77-100.

- ◆ A copy is available at: <http://www.psychcorp.com/>

Edinburgh Postnatal Depression Scale--Cox, J.L., Holden, J.M., & Sagovsky, R. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782-786.

### Examples of Diagnostic Interviews

Schedule for Affective Disorders and Schizophrenia (SADS)--Endicott J., & Spitzer R.L. (1978). A diagnostic interview: the Schedule for Affective Disorders and Schizophrenia. *Arch Gen Psychiatry*, 35, 837-844.

The structured clinical interview for DSM-III-R (SCID)--Spitzer R.L., Williams J.B., Gibbon M., & First M.B. (1992). The structured clinical interview for DSM-III-R (SCID), I: history, rationale, and description. *Arch Gen Psychiatry*, 49, 624-629.

The Composite International Diagnostic Interview (CIDI)--Andrews G., & Peters L. (1998). The psychometric properties of the Composite International Diagnostic Interview. *Soc Psychiatry Psychiatric Epidemiology*, 33(2), 80-8.

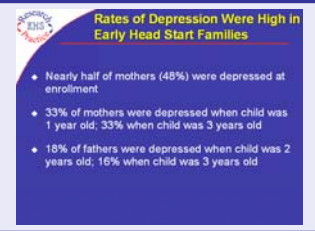
- ◆ Additional information is available at: <http://www.who.int/msa/cidi/>

Nelson, C.B., Kessler, R.C., & Mroczek, D. Scoring the World Health Organization's Composite International Diagnostic Interview Short Form (CIDI-SF; v1.0 NOV98). November 1998.

- ◆ Additional information is available at <http://www.who.int/msa/cidi/index.htm>



## SLIDE 4: Rates of Depression Were High in Early Head Start Families



- ◆ At the time of enrollment, when a quarter of the mothers were pregnant and the rest of the children were under 1 year old, nearly half (48%) of mothers reported enough depressive symptoms to be considered depressed.
- ◆ One third of mothers (33%) were depressed when their children were one year old. In addition, one third of mothers (33%) were depressed when their children were three years old, a reduction from the rate of depression at enrollment (48%).
- ◆ For some women, depression was chronic (12%). This means that mothers were depressed when their child was **both** 1 year old and when their child was 3 years old.
- ◆ Rates of depression for Early Head Start fathers are also notable. Eighteen percent of Early Head Start fathers reported enough symptoms to be considered depressed when children were 2 years old; 16% met those criteria when their children were 3 years old.

## ADDITIONAL INFORMATION

Rates of depression are highest during pregnancy and go down over time. Thus, the rate of depression at the time of enrollment, when one quarter of the mothers were pregnant, would be expected to be higher than after the child is born.

### DISCUSSION QUESTIONS:

- ◆ Do these rates seem consistent with the rate of depression seen in families in your program?

## SLIDE 5: Use of Mental Health Services

**Use of Mental Health Services**

- 23% of Early Head Start families received mental health services by the time they exited the program
- 21% received treatment for emotional or mental health problems
- 5% received drug or alcohol treatment
- When mothers were depressed at enrollment, 32% of families received mental health services

Only 23% of Early Head Start families accessed mental health services by the time they exited the program. Twenty-one percent reported that a family member had received treatment for an emotional or mental health problem and 5% reported that a family member had received drug or alcohol treatment. [Three percent received both types of services.]

Rates of mental health service use were higher for those families in which the mother was depressed at the time of enrollment. Thirty-two percent of mothers who were depressed at the time of enrollment reported that at least one family member received mental health services.

## ADDITIONAL INFORMATION

### DISCUSSION QUESTIONS:

- ◆ How many of families in your program receive mental health services?

## SLIDE 6: Who Accessed Mental Health Services?

Who Accessed Mental Health Services?

- White families more likely than African American or Hispanic families to access services
- English speakers more likely to access services than non-English speakers
- Families in greater need more likely to access services

Clearly, not all families in need of mental health services receive services. So, who is more likely to use services?

Race/ethnicity made a difference in use of mental health services. By the time of exit from Early Head Start, White families (34%) were more likely than African American (17%) or Hispanic families (13%) to have accessed mental health services.

Similarly, English speakers were more likely to have accessed services (27%) versus families who primarily spoke other languages (12%).

Families who accessed services were in greater need. Families who received mental health services reported more maternal and paternal depressive symptoms, family conflict, and child aggressive behavior. Furthermore, those families in which the mothers were depressed at enrollment were more likely to receive services.

## ADDITIONAL INFORMATION

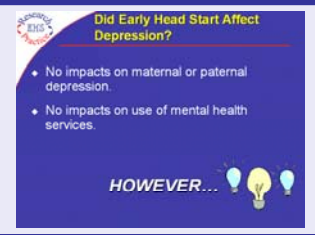
Hispanic mothers and mothers in families in which the primary language was not English reported fewer depressive symptoms and thus may not have been in need of services to the same degree. For example, at 14 months, 33% of White, 33% of African American, and 29% of Hispanic mothers reported elevated symptoms of depression. At 36 months, rates of depression were 37% for White families, 31% for African American families, and 23% for Hispanic families.

This does not totally explain the large differences between use of services by White families versus African American and Hispanic families.

### DISCUSSION QUESTIONS:

- ◆ Do you think that different ethnic/racial groups experience depression differently? Do our assessments capture this?
- ◆ How about mental health services use? Are some people more open to using services? How can services be tailored for particular groups?
- ◆ Can your families access mental health providers who are of the same cultural background? If not, do you think it would make a difference in their use of mental health services?

## SLIDE 7: Did Early Head Start Affect Depression?



Did Early Head Start Affect Depression?

- No impacts on maternal or paternal depression.
- No impacts on use of mental health services.

HOWEVER...

Because the Early Head Start Research and Evaluation Project used a random assignment design, we can determine whether Early Head Start had an impact on depression.

When the families applied to the Early Head Start program, programs accepted applications for twice as many children as could be enrolled. Half were randomly assigned to a control group and half were assigned to a program group. Control group families could not participate in Early Head Start but could receive other community services. So, both groups were the same, except that the program group received Early Head Start and the control group did not. This is important because any differences between the two groups can be attributed to Early Head Start.

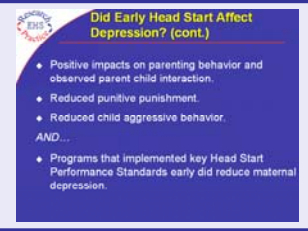
We found that there were:

- ◆ No overall impacts on maternal or paternal depression.
- ◆ No impacts on use of mental health services.





## SLIDE 8: Did Early Head Start Affect Depression? (cont.)



Did Early Head Start Affect Depression? (cont.)

- Positive impacts on parenting behavior and observed parent-child interaction.
- Reduced punitive punishment.
- Reduced child aggressive behavior.

AND...

- Programs that implemented key Head Start Performance Standards early did reduce maternal depression.

HOWEVER, we found:

- ◆ Positive impacts on parenting behavior and observed parent-child interaction
- ◆ Reduced punitive punishment
- ◆ Reduced child aggressive behavior

So, Early Head Start does serve as a protective factor in the lives of children and families.

AND:

Programs that implemented key Head Start Performance Standards early did slightly reduce maternal depression—so it can be done.

## ADDITIONAL INFORMATION

### DISCUSSION QUESTIONS:

- ◆ Why does early implementation of the Performance Standards make a difference in reducing depression?
- ◆ Is it important to have an impact on depression if we do help families in these other ways (i.e., improving parenting, parent-child interaction, and child behavior)?
- ◆ What can programs do to have a larger impact on depression?

## SLIDE 9: Favorable Impacts for Those Depressed at Enrollment



**Favorable Impacts for Those Depressed at Enrollment**

- Especially in parent-child interaction
  - Children: more engaged, more attentive, and less negative
  - Mothers: more positive and less negative in interactions with children
- Also in discipline
  - Less likely to spank
  - Wider array of strategies to cope with parent-child conflict

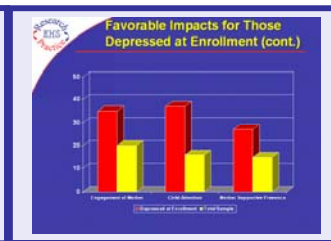
There were many notable positive impacts for those families in which the mother was depressed at the time of enrollment, especially in parent-child interaction and parenting behaviors. Depressed women who were enrolled in Early Head Start were more positive and less negative in interactions with their children, and their children were more engaged, more attentive, and less negative in interactions than their peers who did not receive Early Head Start. Those depressed women who were enrolled in Early Head Start also were less likely to spank their child and they had a wider array of positive strategies to cope with parent-child conflict.

There is some indication that Early Head Start may have slightly reduced depression in those women who were depressed when they enrolled.

These are important findings because they demonstrate that Early Head Start can and does engage women who are depressed and can have important impacts for them and their children, particularly in the area of parenting.



## SLIDE 10: Favorable Impacts for Those Depressed at Enrollment (cont.)



This slide demonstrates the larger effect sizes found for child and mother behavior during a play interaction for those families in which the mother was depressed at enrollment as compared with the overall impacts. We've selected 3 outcomes to illustrate the point—child engagement of mother, child sustained attention, and mother supportive presence during play.

The bars show the size of the impact—how much higher Early Head Start children or families scored relative to the control group. The yellow bar refers to overall impacts for all of the families in the study and the red bar refers to families where mothers were depressed at enrollment.

From this graph you can see that bars for those depressed at enrollment are higher than the overall bar (yellow). This shows that the favorable impacts on the parent-child relationship were particularly strong for those families where the mother was depressed at enrollment. *[Note to presenter: you may decide to stop here.]*

Remember that each bar compares program vs. control. Thus, the yellow bar compares all program families to all control families and the red bar compares those Early Head Start families where the mother was depressed at enrollment to the those families where the mother was depressed at the time of enrollment, but who did not receive Early Head Start services.

## ADDITIONAL INFORMATION

### **DISCUSSION QUESTIONS:**

- ◆ Why do you think positive impacts for parent-child interactions and parenting in particular are strong for mothers who were depressed at enrollment?
- ◆ Is this related to how the program served these families, how families used the program, or another reason?

## SLIDE 11: Implications for Programs



Implications for Programs

- Continue to focus on the parent-child relationship!
- Supportive and responsive relationships with families matter
- Staff need support



Continue to focus on the parent-child relationship! It is critically important to help parents support their children's development and grow in their own roles as parents. A confident mother, father, or caregiver, whether depressed or not, gives the child an enduring gift of worth and value as a person with every responsive interaction. Programs can help parents see how their interactions with their children during everyday routines—dressing, feeding, toileting—have a powerful influence on their child's development. Furthermore, the safe and supportive relationships that staff form with parents are a model for how parents can create a nurturing and supportive environment for their child. The data show us that Early Head Start does support parents in their parenting role, with even stronger impacts for those families in which the mothers are depressed at enrollment. Early Head Start can and does engage women who are depressed and can have important impacts for them and their children, particularly in the area of parenting.

Although Early Head Start staff may not provide mental health therapy to children and families, they can still be therapeutic and supportive in the way they relate to families affected by depression. A high-quality program that meets all the mandates of the Performance Standards may be beneficial in and of itself to depressed parents. Providing social support and emotional connections to parents is an important family development goal that may be immensely helpful to those struggling with depression. In particular, home visiting and family service staff who recognize the signs of parental depression and have knowledge of the mental health referral process in their locale can work to reach out to depressed families and build relationships with them that may assist them in accepting intervention from mental health professionals.

In order for staff to provide the nurturing and supportive environment for families, they must be nurtured themselves. Although the work is rewarding, it can often be challenging to work with families facing mental health issues. Programs need to provide supports for staff, including reflective supervision, mental health consultation, training on mental health issues, and community partnerships to facilitate referral sources.





## SLIDE 12: Implications for Programs (cont.)



**Implications for Programs (cont.)**

- Many Early Head Start families are living with mental illness. Programs must develop strategies for facilitating links with effective treatments that are culturally appropriate.
- Consider including assessment of depression (for both mothers and fathers) at enrollment and follow-ups.

Many Early Head Start families are living with depression and other mental illnesses. Programs must develop strategies for facilitating links with culturally appropriate treatment that is effective. There are many ways that programs can access treatment for families, both within the program and in the wider community. Mental health consultants are used to support staff and work with families or provide timely and effective referrals to mental health services. Community partnerships are also critical for maintaining referral sources.

In order to fully individualize program services for families, program staff should inquire about the mental health status of both mothers and fathers at the time of enrollment and periodically throughout their time in the program. Early care providers are in a unique position to observe families over time and see if problems are fleeting, emerging, or changing over time.

## ADDITIONAL INFORMATION

### DISCUSSION QUESTIONS:

- ◆ What other implications for your program do you see?

## SLIDE 13: Web Resources



Early Head Start National Resource Center (EHS NRC) is a wonderful resource for information for Early Head Start programs.

The Zero to Three organization also has wonderful materials, including their newsletters, which have many articles of relevance. Two of their newsletters in particular are relevant to depression: June/July 2002 and August/September 2001.

Mental Health Toolkit on the Head Start Information Publication Center (HSIPC) web site is another place to explore.

The National Mental Health Association also has useful information.

The Child Outcomes Research and Evaluation web site contains the Report from the Infant Mental Health Forum, information on the new mental health research grants (Early Promotion and Intervention Research Consortium), and the complete Early Head Start research reports.

