

Supporting the
Development of Young
Children in American
Indian and Alaska Native
Communities Who Are
Affected by Alcohol and
Substance Exposure

U.S. Department of Health and
Human Services
Policy Statement



PURPOSE

The purpose of this U.S. Department of Health and Human Services (HHS) policy statement is to support early childhood programs¹ and tribal communities² by providing recommendations that promote the early development of American Indian and Alaska Native (AI/AN) children, prenatal to age eight, who have been exposed to alcohol or substances during pregnancy, or who are affected by parent or caregiver substance misuse during early childhood.

In recent years, tribal leaders and members in many communities have raised the concern of an increase in the number of infants born affected by alcohol and substance use (U.S. Senate Committee on Indian Affairs, 2015). Tribal communities are not the only communities working to address this challenging issue – indeed, states and cities across the country are facing considerable increases in maternal opioid use and the resulting effects on infants (Ko, et al., 2016).). However there has been little research or guidance particularly tailored to building on the unique strengths and meeting the unique needs of tribal communities. This landscape provides the impetus for the focus of this policy statement. It is HHS’s vision that all children, including AI/AN children, regardless of where they live, have access to responsive caregivers, nurturing relationships, and stimulating early learning environments that support their social, emotional, behavioral, cultural/spiritual, cognitive, and physical development.

Experts agree that a sensitive, responsive, and warm caregiving environment can help reduce and even buffer the effects of exposure to alcohol or substance misuse. This makes the role of the early childhood system, specifically early care and education and home visiting, a critical part of the solution. However, early childhood programs in communities that are affected by this issue do not always have the specialized knowledge, appropriate policies, or a workforce that is trained to address the unique needs of children affected by alcohol or substance exposure and their families. The fact that many tribal communities often face higher levels of poverty and less access to resources—such as health, mental health, and behavioral health treatment—makes it especially critical to strengthen early childhood systems in tribal communities so that they can play an active role in addressing this issue. This policy statement will review promising strategies that early childhood programs can implement to help support children’s development, alongside families’ wellness. In addition, throughout this document, we lift up tribal models, promising practices, and approaches as examples of significant contributions to the existing tribal early childhood evidence-, cultural-, and practice-base.

We recognize that the many of the solutions to challenges affecting AI/AN people already exist within tribal communities. This policy statement aims to promote tribal sovereignty³ and nation-building through early childhood development strategies embedded in Native cultures, languages, traditions, and ways of knowing (Tribal Evaluation Workgroup, 2013). At the same time, this document recognizes that

¹ Early childhood programs include any program that provides early learning development supports to parents/primary caregivers and young children prenatally through kindergarten entry, including, but not limited to: private child care, family child care, Head Start, faith-based child care or preschool programs, public and private Pre-K or preschool programs, and home visiting programs.

² Tribal communities encompass both those on tribal lands (e.g., reservations, Alaska Native villages, Tribal Jurisdictional Areas) and non-tribal lands (urban and rural settings).

³ Tribal sovereignty refers to tribes’ right to govern themselves, define their own membership, manage tribal property, and regulate tribal business and domestic relations; it further recognizes the existence of a government-to-government relationship between such tribes and the federal government (U.S. Department of Health and Human Services, 2010; Tribal Evaluation Workgroup, 2013).

compelling Western scientific knowledge around early childhood development and public health can be leveraged to maximize the impact of tribally- and culturally-based approaches to community wellness.⁴

This policy statement advances HHS’s vision for healthy AI/AN children and strong tribal nations, centered on traditional strengths by:

- Raising awareness of the developmental challenges children who have been exposed to alcohol or substances face;
- Highlighting culturally-based and evidence-based strategies⁴ to support the early development of AI/AN children, their families, and communities;
- Supporting tribal efforts to coordinate and leverage services and activities across communities to benefit young children, families, and communities; and
- Identifying culturally and linguistically responsive resources to support tribal communities, early childhood programs, and families in fostering the early development and learning of AI/AN children.

BACKGROUND

Diverse in heritage and geography, the AI/AN population makes up approximately two percent of the total U.S. population, or 5.4 million people. There are currently 567 federally-recognized tribes in the U.S. and many other state-recognized tribes (U.S. Department of the Interior, 2016). In 2010, the U.S. Census provided data for more than 617 American Indian legal and statistical areas including 334 federally and state recognized reservations. AI/AN communities and cultures are extremely diverse. These communities have many strengths, protective factors, dedicated leaders and traditional healers, and a history of resilience in the face of historical trauma – including the disruption of language, culture, spirituality, and ties to ancestral lands – and large social, health, and economic disparities. It is important to understand both the strengths of tribal communities and families and how history and trauma contribute to the challenges currently facing AI/AN communities.

While it is essential to elevate and build upon the resiliency and strengths of tribal communities, it is also important to recognize that the AI/AN population, as a whole, faces a number of disparities in access to resources, such as good jobs and health care. Disparities experienced in tribal communities, paired with ongoing discrimination, as well as historical and intergenerational trauma—the collective emotional and psychological suffering, manifesting throughout the life span and passed down through generations, can have a significant impact on alcohol and substance use and consequently, on children’s developmental trajectories (Brave Heart, et al., 2011).

Compared to other racial and ethnic groups, AI/AN communities (living both on and off of reservations) face poverty rates of 28.3%, the highest rate of any race group and considerably higher than the national average of 15.5% (Norris, Vines, & Hoeffel, 2012). Thirty percent of AI/AN children live in high poverty areas (U.S. Census Bureau, 2014).⁵ AI/ANs are also disproportionately represented among individuals experiencing homelessness (U.S. Interagency Council on Homelessness, 2015).

⁴ It should be noted that culturally-based and evidence-based are not necessarily distinct or opposed concepts. Many culturally-based approaches are based on evidence (including those derived from tribal practice) that Native communities have gathered, analyzed, tested, and improved over millennia.

⁵ High poverty areas are defined here as census tracts where the poverty rates of the total population are 30% or more.

Along with higher poverty rates the AI/AN population has less access to basic health, mental health, and behavioral health services. The Indian Health Services (IHS) system, which is responsible for providing federal health services to AI/AN people as part of the federal-Indian trust responsibility, is drastically underfunded compared to other public healthcare systems like Medicare, Medicaid, and Veteran's Health Services (Warne & Frizzell, 2014). In 2015, even after several years of increases in the agency budget, funds available to IHS per user were nearly one-third the national average spending per user (National Indian Health Board, 2016).

This lack of access to basic health services has contributed to AI/AN people experiencing preventable and chronic disease at a higher rate compared to other racial and ethnic groups. Compared to Non-Hispanic White adults, AI/AN adults are significantly more likely to be obese, be diagnosed with diabetes and heart disease, and have a stroke (HHS, 2012). AI/AN infants are the most likely of any racial or ethnic group to have mothers who began prenatal care in the third trimester or did not receive prenatal care at all, and infant mortality rates and death rates from Sudden Infant Death Syndrome are 1.5 and 2.0 times the rate of the Non-Hispanic White population, respectively (Centers for Disease Control and Prevention (CDC), 2015; Child Trends, 2015).

As compared to the general U.S. population, the prevalence of adult mental illness is also greater among AI/ANs (Dean, et al., in press; Center for Behavioral Health Statistics and Quality, 2015). Preliminary findings from the Head Start AI/AN Family and Child Experiences Survey show that approximately 42% of parents, primarily mothers, served by Region XI Head Start⁶ programs reported symptoms of mild to severe depression (Malone, Bernstein, & West, 2016). Many contextual factors are associated with depression, including stress, adversity, and poverty (Institute of Medicine, 2009). Mood and anxiety disorders in many AI/AN communities may be further impacted by community-level trauma and historical trauma, in addition to inadequate access to health and mental health care, healthy nutrition, secure housing, safe physical environments free of toxic pollutants, and educational and economic opportunities (Sparrow, 2016). In addition, suicide rates among AI/AN people are significantly higher than that of the general population and Native teens experience the highest rate of suicide of any population group in the United States (Center for Native American Youth, 2010; Suicide Prevention Research Center, 2013). Research has shown this increased risk is correlated with disruption of cultural identity during a developmental period when identity is being formed (Chandler & Lalonde, 2008).

The confluence of higher poverty rates, less access to physical health, mental health, and behavioral health services, and poorer health and mental health outcomes, as well as historical and continued trauma, contribute to higher rates of misuse for many types of substances in some AI/AN communities. In general, substance use and dependence occur at a rate more than double the national average (14.9% vs. 6.6%). For example, AI/ANs report 1.6 times higher rates of tobacco product use, 1.3 times the rates of current illicit drug use, and nearly two times the rate of nonmedical prescription pain reliever use as the general U.S. population. Though AI/ANs report lower rates of current alcohol use than the general population (37.3% vs. 52.2%), binge drinking is higher among AI/AN populations (23.5% vs. 22.9%). Cigarette smoking is more common among AI/ANs than almost any other racial/ethnic group in the United States. In addition, AI/AN women report the highest rates of smoking during pregnancy of all U.S. racial or ethnic groups. Furthermore, co-occurring mental illness and substance use disorders in AI/AN populations are more than double that of the general U.S. population (Dean, et al., in press; Child Trends, 2013). The effects of alcohol and substance misuse on young children's development can be

⁶ The Office of Head Start operates 12 Regional Offices that support the administration of grants, oversight, and training and technical assistance for Head Start programs. Region XI covers the 148 Head Start AI/AN programs in the various states.

profound, especially when the exposure results in conditions like Fetal Alcohol Spectrum Disorders and Neonatal Abstinence Syndrome.

Fetal Alcohol Spectrum Disorders

In 1996, the Institute of Medicine reported that, “of all substances of abuse (including heroin, cocaine, marijuana), alcohol produces by far the most serious neurobehavioral effects in the fetus” (Sratton, Howe, & Bataglia, 1996). Fetal Alcohol Spectrum Disorders (FASD) are the leading causes of preventable intellectual disability, birth defects, and learning and behavioral disorders in the United States (Tavener Mitchell, 2016). FASD is an umbrella term that represents all disorders associated with maternal alcohol consumption during pregnancy, including fetal alcohol syndrome, partial fetal alcohol syndrome, alcohol-related neurodevelopmental disorder, and neurodevelopmental disorder associated with prenatal alcohol exposure. Experts estimate that the full range of FASDs in the United States might be as high as two percent to five percent of the population (May, et al., 2014). However, researchers suggest that the condition may be under or mis-diagnosed and may be higher in certain populations.

Public Awareness: Partnerships between the National Organization on Fetal Alcohol Syndrome and Tribal Organizations

Led by a Native planning committee, [partnerships](#) between the National Organization on Fetal Alcohol Syndrome (NOFAS), National Congress of American Indians, National Indian Health Board, and Indian Gaming Association has worked hard to increase public health initiatives and implement clinical practices and intervention strategies in Indian Country. They have initiated public awareness campaigns, teen peer-to-peer projects, trainings for practitioners, and support groups such as the [Circle of Hope](#). Tribal partners have included the Navajo Nation, Cherokee Nation, Standing Rock Sioux Tribe, Oneida Nation, Mississippi Choctaw, Nez Perce, Minnesota Ojibwe, and Soboba Band of Luiseno Indians. NOFAS has also supported the implementation of CDC’s [CHOICES](#) in clinical settings that serve AI/AN women of childbearing age.

Alcohol is toxic to the growing fetus and has lifelong impacts. While there are characteristic facial features associated with some FASD cases, many of those affected do not have visible, physical symptoms. As a result, many individuals with FASD may never be diagnosed. Many of the symptoms of FASD in young children can be challenging for both parents and educators, especially if they are not recognized as FASD. Babies with FASD often have sleep and sucking problems that result in feeding challenges. They may develop vision or hearing issues and problems with the heart, kidneys or bones. Children with FASD may have poor coordination, hyperactive behavior, difficulty with attention, poor memory, learning disabilities, speech and language delays, intellectual disabilities or low IQ, poor reasoning and judgment skills, and difficulty in school (CDC, 2016). Unfortunately, symptoms are often misidentified and receive a diagnosis of Attention Deficit Hyperactivity Disorder rather than a developmental delay. In some cases, children are seen as having behavioral issues that result in suspension and expulsion from educational settings. However, externalizing behaviors are often a result of a lack of appropriate supports, individualized learning, and accommodations within the classroom environment.

There is no cure for FASD, but early intervention can improve child development and outcomes. Protective factors outlined by the CDC include:

- Diagnosis before six years of age;
- Loving, nurturing, and stable home environment;
- Absence of violence; and
- Involvement in early intervention, special education, and social services.

Common Symptoms of Neonatal Abstinence Syndrome

- Blotchy skin coloring (mottling)
- Diarrhea
- Excessive crying or high-pitched crying
- Excessive sucking
- Fever
- Hyperactive reflexes
- Increased muscle tone
- Irritability
- Poor feeding
- Rapid breathing
- Seizures
- Sleep problems
- Slow weight gain
- Stuffy nose, sneezing
- Sweating
- Trembling (tremors)
- Vomiting

Although FASDs are related to various levels of alcohol use, such disorders are more likely to occur with maternal binge drinking. AI/ANs report lower rates of alcohol use as compared to the general population, but as noted above, some data indicate that binge drinking is more prevalent (Kanny, Liu, Brewer, & Lu, 2013; Stanley, Harness, Swaim & Beauvais, 2014). FASD is a significant issue in many AI/AN communities and many tribal communities lack access to screening, diagnosis, and behavioral supports for children who are diagnosed (Centers for Disease Control and Prevention, 2002; SAMHSA, 2007). Furthermore, there is a negative stigma associated with FASD that may provide a disincentive for families to seek support.

Neonatal Abstinence Syndrome

According to the National Institute on Drug Abuse, a baby is born suffering from opioid withdrawal every 25 minutes, leading to an average hospital stay of 16.9 days versus 2.1 days for a non-opioid exposed child and an additional \$1.5 billion in hospital costs annually (Patrick, et al., 2012). Newborns who have been exposed to opiates in-utero may experience Neonatal Abstinence Syndrome (NAS). Some tribal leaders have reported NAS as a growing issue in their communities (U.S. Senate Committee on Indian Affairs, 2015).

Depending on the severity of drug withdrawal, babies born with NAS may suffer from poor sensory integration, respiratory issues, hyperactivity, seizures, fever, lack of sleep, and uncoordinated sucking and swallowing during the first 48 to 72 hours after birth (Patrick, et al., 2012). Consequently, infants with NAS are irritable, engage in excessive or high pitched crying, have difficulty latching to breastfeed, and have problems with general eating and digestion. Frequently, these babies do not like to be touched and are difficult to soothe, profoundly impacting the first days of bonding between parent and child. Regulatory and attachment issues may also be present.

In communities where there is access to health care, infants with NAS may stay in the Neonatal Intensive Care Unit from days to weeks, depending on severity of withdrawal, weight loss, illness and any number of other medical issues. Most of these symptoms will diminish as the child gets older, though some symptoms, such as tremors, could last for months. While impacts on cognitive

development are unclear, children born with NAS appear to be more likely to have behavioral problems such as a poor attention span, hyperactivity, and challenges with self-regulation.

In a recent study of 28 states that examined general trends in NAS and maternal opioid use, the overall NAS incidence increased 300% between 1999 and 2013. However, there is great variation in prevalence rates across the United States. In 2013, the NAS incidence ranged from 0.7 cases per 1,000 hospital births in Hawaii to 33.4 cases per 1,000 hospital births in West Virginia (Ko, et al., 2016). Some believe the increase in incidence is related to a shift in drug addiction treatment strategies (Logan, Brown, & Hayes, 2013). One such strategy is *drug replacement therapy*, which replaces opiates with a longer acting, but less euphoric opioid, such as methadone or buprenorphine, to reduce harm, wean off drugs, and prevent patients from experiencing symptoms of withdrawal. Replacement therapy is the treatment of choice for drug-addicted pregnant women; it is safer for the developing fetus than continuing to use street drugs or stopping drug use completely during pregnancy. Approximately 50% of women on methadone during pregnancy will have a baby in need of treatment for NAS. Unfortunately, many who use replacement therapy also continue to use alcohol (Neptune, 2016). During pregnancy, many mothers are not aware of nor prepared for the effects of drug use and replacement therapy on their newborn infants.

The medical focus on NAS is short-term and often not accompanied by a focus on helping the mother learn to care for her baby, who may be very difficult to feed and to comfort, and less able to provide her with strong attachment cues. Similarly, the attention devoted to the acute treatment of NAS is often not matched by efforts to help the mother accept and follow through on treatment for substance misuse, though this support may be critical. There are also predictable developmental challenges in the first two years that may be more difficult for mothers who are working toward recovery to navigate. Combined, these factors can threaten the mother-child relationship and predispose the child to abuse. These challenges may be addressed by anticipatory guidance from medical professionals and early education programs, combined with additional supports, such as home visiting (Sparrow & Brazelton, 2011).

Research is sparse on long-term developmental outcomes associated with prenatal opiate exposure (de Cubas & Field, 1993; Kocherlakota, 2014; Logan, Brown, & Hayes, 2013; Minnes, Lang, & Singer, 2011; Neptune, 2016). Identifying the unique effects of opioid exposure on young children is difficult. In many cases, more than one substance is involved, and substance exposure is accompanied by other factors

Supporting Families Dealing with Neonatal Abstinence Syndrome

To alleviate the effects of NAS, it is essential to support caregiver-child attachment during this critical time of child development, regardless of shame or stigma associated with substance misuse and, often, co-occurring mental illness. It is especially important for parents to be aware of opiate withdrawal symptoms prior to birth so that they have realistic expectations for developing a relationship with and caring for their child. It may be difficult and disheartening for the mother to soothe and comfort their infant during the early days of withdrawal. The mother's social support network must also understand the implications of prenatal substance misuse and how to best support the new mother and family.

such as trauma and poverty, each of which affect fetal development in the short term, and child development in the long term. In addition, the changing landscape of drug-type use makes it challenging to have information on the drugs being used with the highest prevalence today. Given these challenges, researchers and policy makers rely on drawing lessons learned from the effects of previously studied drugs, such as cocaine. Findings from those studies indicate that long term effects are highly dependent on the quality of the caregiving environment, which suggests that these effects may be mitigated with access to the appropriate supports for families to foster children’s early development.

Principles in Support of Tribal Children’s Social, Emotional, and Behavioral Development

Understanding children’s environments, including the impacts of challenges like adult alcohol and substance misuse, is critical to identifying trauma-informed strategies that support early development and build on AI/AN families’ and communities’ strengths in healing and resiliency. A concerted effort to support the development of all AI/AN children, including those affected by exposure to alcohol or substances, must include addressing both their needs and the needs of the adults who surround them. Tribal communities can consider applying the following underlying principles broadly across contexts and services for adults and children to help forge a path toward healthy development of the youngest AI/AN children, as well as wellness for the adults who care for them.

- *Building on Cultural Strengths and Traditions*
Cultural assets have the potential to protect AI/AN children against environmental stressors that contribute to developmental challenges (Jumper-Reeves, et al., 2014). All humans benefit from knowing who we are, where we come from, how our cultures influence the way we live, our roles in our families and communities, and the future that we see for ourselves. This truth is paramount in tribal communities where historical injustices, such as boarding schools, disrupted that essential knowledge and connection and made it difficult to maintain. Building on traditional and cultural strengths includes acknowledging and celebrating families’ cultural identities, supporting parent’s and children’s connections to traditional indigenous practices, and championing their acquisition and use of Native languages. Many traditional Native beliefs and practices have evolved and been tested over millennia to be inherently supportive of children’s healthy development and wellbeing. Culturally-grounded practices have the potential to prevent, address, and heal trauma and set tribal communities on a stronger path forward (Smith, 1999; Okamoto, et al., 2014). The revitalization of culturally-based practices also recognizes that while the problems facing tribal communities are historical and systemic, so are the solutions.
- *Taking a Developmental, Strengths-Based, and Reflective Approach*
Working with families who are struggling with alcohol and substance misuse requires sensitivity and careful consideration of approach. Across programs and services, providers should support families in their journey to healing by taking developmental, strengths-based, and reflective approaches. A **developmental approach** means supporting children’s development – whether it is on-track, delayed, or atypical, and ensuring that the support offered is grounded by a fundamental understanding of child development. This is particularly important for children who are affected by substance exposure in-utero given the association with developmental challenges. Development is lifelong, and parents and other adult caregivers’ developmental paths can also be considered as specific supports are selected for healing, and hope is offered for recovery.

Similarly important is taking a **strengths-based approach that prioritizes healthy relationships** by building on children and families’ strengths, including cultural and linguistic strengths. Caregiver-

child relationships must be supported regardless of the stigma associated with substance-exposed pregnancies and births and child maltreatment (see box, “Supporting Families Dealing with Neonatal Abstinence Syndrome”). A relational and strengths-based approach to working with families can help overcome stigma and bring people together in positive ways that build trust, make everyone stronger, and allow for creativity in leveraging and maximizing resources and opportunities.

Finally, it is important to adopt a *reflective approach* when working with families. In many tribal communities, teachers, home visitors, and other staff working with children and families are themselves community or tribal members who have similar strengths and face similar challenges as the families they work with. It is critical that staff at all levels recognize what they bring to each interaction and have an opportunity to reflect on their perspectives and experiences.

- *Using Trauma-Informed Approaches to Well-Being*

Given the complex historical, intergenerational, and at-times ongoing trauma faced by many children and families living in tribal communities, taking a trauma-informed approach is essential to promoting children’s development, supporting families, and fostering community transformation and healing. In many cases, alcohol and substance misuse, as well as children’s responses to supports and intervention, may be associated with this ongoing and historical trauma. Individuals’ experiences with and recovery from trauma can be influenced by the community context. By understanding trauma and how it manifests in the context of their settings and services, tribal communities can implement approaches that build on traditional cultural strengths, promote resilience, and are more likely to be effective.

Addressing trauma requires a trauma-informed approach that crosses agencies and services, and is inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment (see box, “Promising Practice: Head Start Trauma Smart and the Menominee Nation”). A program, organization, or system that is trauma-informed 1) realizes the widespread impact of trauma and understands potential paths for recovery; 2) recognizes the signs and symptoms of trauma in clients, families, staff, others involved with the system, and community institutions and interactions; 3) responds by fully integrating knowledge about trauma into policies, procedures, and practices; and 4) seeks to actively prevent re-traumatization (SAMHSA, 2014). A trauma-informed system also actively and effectively spreads the message that healing and recovery are within reach. These general guidelines for a trauma-informed approach can be tailored for tribal communities through the integration of Native cultures, languages, and ceremonies.

- *Taking a Two Generation/Intergenerational Approach*

Children learn, grow and develop in the context of healthy relationships with adults. As such, children’s wellness is inextricably linked to the wellness of the adults around them. Adult wellness, in turn, is influenced by a confluence of factors like health, mental and behavioral health, trauma and adversity, employment and income, and social capital, among others factors. All adults around children need support for their own wellness – particularly those who are struggling with alcohol and substance misuse challenges – in order to support the healthy development of children.

Two generation/intergenerational approaches combine intensive high-quality adult-focused services with intensive high-quality child-focused programs. As previously described, adult caregivers in tribal communities are disproportionately likely to face health and wellbeing challenges that affect their emotional wellness and ability to support children. A two-generation/intergenerational approach to

supporting children’s development addresses children and adults’ health and wellness individually, alongside the wellness of their relationship, through services like culturally responsive parenting interventions. Access to preventive supports, screening, intervention, and treatment, as needed, is critical to advance caregiver and child wellness, foster healthy caregiver-child relationships, and promote children’s early development.

Those supporting adult health and wellness must also consider the health and wellness of the early childhood workforce, who spends a significant amount of time with young children. Sustained institutional supports can assist in these efforts, including systems-wide screening and access to health and mental health services for staff, paired with ongoing professional development to increase self-efficacy and decrease stress; adequate staff compensation; reflective supervision and reflective practice⁷; access to supports from specialists through infant and early childhood mental health consultation⁸; and strong ties to their AI/AN culture, language, and community identity.

RECOMMENDATIONS FOR MOVING FORWARD

Although more research is needed to identify specific strategies and practices that fully address the unique needs of AI/AN children who are affected by exposure to adult alcohol or substance misuse, experts agree that a culturally responsive, stable, enriched, and warm caregiving environment can serve as an important buffer against the effects of substance exposure. The recommendations that follow build on the above principles and are informed by knowledge about how to support children’s early development – particularly knowledge about children’s social, emotional, and behavioral development; research on optimizing parent and caregiver success; and an understanding that strengths-based, developmental, and reflective approaches, grounded in culture can be particularly effective in working with young children and families in tribal communities. These recommendations are intended for early childhood programs in tribal communities, tribal and community leaders, and federal, state, local, and philanthropic partners.

Recommendations for Early Childhood Programs in Tribal Communities

Early childhood programs in tribal communities, including early care and education and home visiting programs, have the ability to support a healthy developmental trajectory – including a strong social, emotional, and behavioral foundation for children impacted by exposure to adult alcohol and substance misuse. Early educators and other early childhood staff can serve as stable, warm and sensitive caregivers while children are in their care; work with families to promote prevention, raise awareness of the effects of substance misuse on children, and foster healthy parent-child relationships; and screen children for developmental issues and refer them to appropriate specialized service providers. Programs should implement the following recommendations to better support children affected by exposure to alcohol or other substances.

⁷ Reflective supervision is a collaborative relationship for professional growth. It improves program quality and practice by valuing strengths and partnering around vulnerabilities to generate growth. Reflective supervision gives staff the chance to gain a deeper understanding of their own beliefs and how those beliefs impact their work with families. They also refine their ability to see other people’s perspectives and use that information to build stronger relationships. <https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/comp/reflective-supervision>

⁸ Infant and Early Childhood Mental Health Consultation (IECMHC) is a multi-level preventive intervention that teams mental health professionals with people who work with young children and their families. The model builds the capacity of early childhood teachers, home visitors, and families to promote social-emotional and behavioral development and has demonstrated impacts for improving children’s social skills and adult-child relationships; reducing challenging behaviors, expulsions and suspensions; increasing family-school collaboration; increasing classroom quality; and reducing teacher stress, burnout, and turnover. In contrast to direct therapeutic services, IECMHC offers an indirect approach to promoting positive social and emotional development among children and families. <http://www.samhsa.gov/iecmhc/about>

A. Ensure that staff, understand the prevalence and impact of alcohol and substance exposure on children, what they can do about it, and how to partner and communicate with families.

Program leaders should provide trainings and briefings for staff on the effects of alcohol and substance misuse on the developing fetus and on children’s later development, while emphasizing the importance of not judging parents, building strong relationships with them, and focusing on their strengths in order to work together for child and parent recovery. Program leaders should ensure staff are aware of the prevalence of this issue, specific behavioral, developmental, and learning challenges that may present in a child who has been exposed, specific practices and environmental modifications they can implement to support children, and community resources that can assist families with managing these issues. Early childhood programs should incorporate the following issues into staff training:

- Forming strong relationships with families – including, as applicable, biological parents, grandparents and other caregivers, foster parents and adoptive parents;
- Communicating with families who are struggling with alcohol and substance misuse;
- Identifying, understanding, and addressing biases about alcohol and substance misuse, in order to engage with families in a positive, strengths-based, and non-judgmental way;
- Understanding trauma, the signs of trauma, the impacts of trauma on children’s development, and how to work with children who have been exposed to trauma;
- Understanding the signs of neglect and abuse, where to report it, and how to support children who have been abused or neglected;
- Supporting children’s development across all domains, including children who are developing typically or children who may be delayed in their development; and
- Conducting developmental and behavioral screenings, talking to families about results, monitoring results over time, and referring children for additional services, if needed.

It is critical to support staff in communicating and partnering with families. It is possible to help parents and caregivers move past shame and stigma of alcohol and substance misuse and other challenges, including when those challenges have resulted in the birth of children with NAS or FASD, through supportive, relationship-based interventions that meet families where they are – throughout pregnancy and a child’s early years (see box on “Lake County Tribal Health Consortium Addresses Substance Use and Its Impacts”). Early childhood program directors should ensure that all staff recognize that alcohol and substance misuse are not the fault of the person with the disease, and are not within that person’s control. Addiction is often a chronic or relapsing disease, supports are needed over the long term, and a relapse is not a sign of failure, but something to be prepared for and expected.

B. Raise awareness with families about alcohol and substance misuse and its effect on children.

Early childhood programs should promote prevention of alcohol and substance misuse during pregnancy and parenthood. This may be especially important for families who have struggled with alcohol and substance misuse in the past and are expecting or plan to have another child in the future. Programs should ensure that the families that they serve are aware of the prevalence and effects of alcohol and substance exposure on children during pregnancy and throughout early

childhood, and the resources they can turn to if they or their family members need help. Programs should share this information in a way that is culturally responsive and is careful to avoid perceptions of blame or judgment and prevent stigma (See box on “The Community Caring Collaborative Bridging Program”). A strong partnership between families and providers sets the foundation for discussing more difficult issues. In addition, programs can partner with health, mental health, and behavioral health providers to share information with families and raise awareness in the community about opportunities for prevention and treatment.

Case Study: Lake County Tribal Health Consortium Addresses Substance Use and Its Impacts

Under its 2010 ACF Tribal Maternal, Infant, and Early Childhood Home Visiting grant, the [Lake County Tribal Health Consortium](#) (LCTHC) in northern California conducted a comprehensive community needs and readiness assessment. Lake County has a population of 66,000, with about 5 percent of AI/AN descent. Most of the AI/AN population is represented by 111 tribes, with the majority from six Pomo tribes, including four reservations called “Rancherias.” LCTHC is a consortium of the six tribes and offers medical, dental, public health, and human services, funded by IHS, county, state, and other federal grants. LCTHC’s assessment revealed a wide range of strengths and challenges that [include some of the following concerns](#):

- Alcohol and substance use
- Maternal depression
- Substance-exposed pregnancies and births
- Family violence
- Lack of school success

Many of these challenges can be linked to historical and inter-generational trauma experienced by the Native population—most recently the termination and forced relocation of the Pomo tribes in the latter part of the 20th century. Community members view the tribal home visiting program as an opportunity for hope and healing.

As a result of the needs assessment, LCTHC is implementing the [Parent-Child Assistance Program \(PCAP\)](#), a case management-based home visiting model from the University of Washington with a focus on preventing substance-exposed pregnancies and births as well as Fetal Alcohol Spectrum Disorder. PCAP is adaptable and flexible to community needs and based on the relationship between the family advocate (home visitor) and the client. LCTHC has supplemented the PCAP with the [Nurturing Parenting](#) curriculum and has also incorporated cultural activities and teachings into their tribal home visiting program. Since beginning home visiting services in 2012 to Native families who are pregnant and/or have children up to age five, LCTHC improved outcomes for children and families, including increases in rates of health insurance; well child visits and immunizations; pre-natal visits; use of medical and dental services; use of family planning methods; rates of GED and adult education enrollment; and improved safety planning by families.

C. Implement practices and make environmental modifications for children with NAS and other infants affected by in-utero exposure to substance.

Some early childhood programs will serve young infants with NAS or a history of NAS, and other young infants who have been affected by in-utero exposure to substances. Although research is ongoing on how best to support these infants, a growing knowledge base suggests that there are a

number of environmental modifications and practices that early childhood programs can implement. These environmental modifications and practices can and should be implemented across the settings where children are – including the home, the early childhood program, and any other setting where the child spends time.

- **Partner with families and ensure clear and constant communication:** Early childhood programs should have close communication with families and partner with them in implementing the recommended practices below. Partnership with parents and all primary caregivers is key so that both primary caregivers and early childhood providers are on the same page and consistently using the same strategies, feeding and sleep schedules, and making the same environmental modifications to best support the infant. Infants with NAS or a history of NAS, may face an array of challenges and they should be addressed consistently across settings. Early childhood programs should also ensure that they have a way to contact families at all times and that they discuss the child’s difficulties and progress at the end of each day, or more often when necessary.
- **Partner with other service providers:** In addition to ensuring strong partnerships and communication with families, early childhood programs (with family permission) should also partner with other service providers, especially the child’s medical providers, and other specialists providing services, such as an early interventionist or social worker. A team approach to promote consistency across settings and practices is critical. In addition, early childhood programs should know how to contact the child’s medical home and other service providers if they have serious concerns or face an emergency and cannot contact the family.
- **Decrease sensory stimulation:** In many cases, infants with NAS, a history of NAS, or other in-utero substance exposures are easily overly stimulated. They may have hyperactive reflexes, increased muscle tone, rapid breathing, sweating, tremors, and excessive sucking, though some of these difficulties may occur in the first weeks after birth and may subside thereafter. Experts recommend decreasing the stimulation in their environment by using subdued and incandescent lighting, reducing noise, and ensuring the temperature is stable. Often, these children can more easily handle stimulation in one sensory channel at a time (sight, hearing, touch), rather than in combination.
- **Take supportive measures to keep infants calm and comfortable:** Because of the array of difficulties infants with NAS or a history of NAS may experience, they may cry excessively in a high-pitched tone and have difficulty sleeping. In such cases, early childhood providers should hold the infant close to them, and swaddle, rock, sway, or walk. Playing soft gentle music or speaking softly to the infant in a darkened room to reduce visual stimulation may also help. Ensure that the infant’s diaper is clean and that he or she is fed if he or she is hungry.
- **Feed smaller and more frequent meals:** Infants with NAS may experience difficulties with feeding, sucking, and swallowing. If this is the case, early childhood providers can try feeding the infant smaller, but more frequent meals. Feeding should also be done in a calm and quiet place and should be done slowly, giving the infant time to pause between sucking intervals. If the infant is sucking excessively, early childhood providers can alternate between pacifiers and the bottle. Burp the infant after he or she feeds or sucks on the pacifier.

- **Prevent and address skin irritation:** Infants with NAS may suffer from diarrhea, which makes them more susceptible to skin rashes or irritation. Early childhood providers should ensure that diapers are checked regularly and that soiled diapers are changed immediately using warm water. Infants with NAS may also excessively suck their hands or their thumbs, which over time can cause skin irritation. If the infant is excessively sucking, avoid lotions and creams and try to cover his or her hands with gloves. If the skin becomes irritated, make sure to keep it clean with baby soap and water.
- **Ensure safe sleep practices:** Early childhood providers should ensure that they implement safe sleep practices by always placing babies on their back to sleep. Providers should ensure that they monitor the infants as they sleep in case of vomiting, which may be more likely with NAS. Ensure that infants and their bedding are always clean.
- **Monitor infants closely:** Infants with NAS may experience an array of symptoms that require careful monitoring. They may experience increased sneezing or a stuffy nose. Early childhood providers should ensure that infants' noses and mouths are clear, monitor their breathing, and contact the family or with the family's permission, the child's medical home, if breathing troubles ensue. Infants with NAS may also be more likely to have fevers, which are important to monitor. Providers should contact families if the infant has a fever and seek medical attention if the fever is elevated for more than four hours or other symptoms develop.

D. Implement strategies that build self-regulation and co-regulation in children, parents, and providers.

Self-regulation has been defined as the act of managing cognition and emotion to enable goal-directed actions such as organizing behavior, controlling impulses, and solving problems constructively. Self-regulation can be defined, manifested, and promoted differently in different cultures. Research indicates that self-regulation serves as the foundation for lifelong functioning, from mental health and emotional wellbeing to academic achievement, physical health, and socioeconomic success. Self-regulation can be disrupted by prolonged, elevated levels of stress and adversity. Self-regulation skills that are not developed in early childhood, however, can be acquired later in life making these skills an important focus of intervention, particularly for families who may have gone through high levels of stress and adversities associated with alcohol and substance misuse (Murray, et al., 2015).

Children's development of self-regulation is also dependent on "co-regulation" provided by parents or other caregiving adults. Through their interactions, adults and young children modulate each other's thoughts, feelings, and behavior. This process helps children understand, express, manage their feelings, and to understand those of others. Adults' abilities to participate in co-regulation is influenced by their own ability to self-regulate.

Early childhood programs have an important role in supporting child self-regulation and facilitating provider co-regulation skills. Early childhood programs should ensure that providers use:

- Warm and responsive caregiving by reading children's cues accurately, and responding to their needs sensitively and consistently;
- Effective teaching skills that follow children's interests and provide multiple opportunities for learning across all interactions and activities; and

- Classroom management strategies that promote social, emotional and behavioral development and decrease chaos, over-stimulation, and the likelihood for challenging behavior.

Early childhood programs should also work with parents and families to build their own confidence to provide warm and responsive interactions, establish routines, teach rules and consequences, and talk with children to identify solutions and manage emotions in a developmentally appropriate way. To be effective in supporting the development of self-regulation and co-regulation in their children, families may benefit from a range of supports to reduce their stress and address any unmet needs.

Promising Practice: Community Caring Collaborative Bridging Program

Washington County, Maine is home to 33,000 people, 3,600 of which are from the Passamaquoddy Tribe. While 73% of Passamaquoddy report being in excellent, very good, or good health, 30% suffer from substance abuse issues and 18% have problems with alcohol. Washington County has experienced an epidemic of prescription drug abuse and overdose (CDC, 2014). Compared to 10% of other Maine women, 34% of Passamaquoddy women reported binge drinking in the last month (University of New England, 2013). These challenges exist against a backdrop of rural isolation coupled with high unemployment, intergenerational poverty, poor life expectancy, and limited support services. For example, most families must travel 90 miles or more to receive hospital care.

With initial funding from [Project LAUNCH](#), the [Community Caring Collaborative](#) (CCC) began in 2006 to create a strengths-based system of care to meet the needs of Washington County's most vulnerable children and families. Together with community-based non-profits and volunteers, the CCC is a partnership of more than 45 tribal, county and state agencies that provide infant and family support specialists in community health centers, early childhood mental health consultation, and trauma-informed professional development. The CCC also implements the [Bridging Program](#), a strengths-based approach to serving families with high risk infants through wrap-around mental health services, [Touchpoints](#) parenting education, Early Intervention, and integrated clinical and public health resources.

Services are individualized, flexible, and offered at the family's location of choice. All pregnant women on replacement drug therapy for opioid misuse are offered enrollment. Foundational to the model is a commitment to reducing feelings of hopelessness and cultivating wellness through trusting relationships with health/parent education professionals that support clients' strengths and self-efficacy. Both nurse and parent educator "bridgers" receive training on human development, trauma-informed care, strengths-based intervention, poverty, and collaboration. Participation in the Bridging Program has been associated with decreased time spent in neonatal intensive care units, hospital readmission, and visits to the emergency room. Providers report enhanced collaboration across family-serving agencies, relationship-building across providers and between providers and families, and attitudinal shifts among families from hopelessness to hopefulness (Morton, et al., 2015).

Principles of developing self-regulation and co-regulation resonate strongly with many traditional cultural practices in tribal communities – including a worldview that emphasizes interconnectedness and interdependence. Ceremony, smudging, and storytelling, as well as childrearing practices such as the cradleboard and infant massage can all promote co-regulation. In many AI/AN cultures, it is understood that adults help children learn and grow by talking with them and teaching them, not

through punishment. These traditional tribal practices are examples of ways to support self-regulation across programs and services, and can be built upon, both in the classroom and in the home, rather than replaced with or disrupted by Western interventions.

E. Engage families and expand the use of positive parenting practices.

Early childhood programs should ensure that staff have [relationship-building competencies](#) that facilitate strong partnerships and engagement with families, including biological, adoptive, and foster families. As laid out in a federal policy statement from the U.S. Departments of Health and Human Services and Education, strong family engagement by early childhood programs is central in promoting children's healthy development and wellness, including social, emotional, and behavioral development; preparing children for school; seamlessly transitioning them to kindergarten; and supporting academic achievement in elementary school and beyond (HHS & ED, 2016).

Developing trusting relationships with families enables strong partnerships and is especially important in cases where families are managing challenging issues, such as alcohol and substance misuse and its effects on children. These relationships are pre-requisites to supporting families well and, once established, can serve as the foundation to more extensive support.

Early childhood programs should facilitate caregivers' social connectedness and help parents feel less alone and more able to access support through [connections to other families or to community resources](#). These connections can serve as an important buffer to a number of stressors, including mental health issues that may be related with alcohol and substance misuse challenges.

Programs should reinforce feelings of parental self-efficacy by eliciting parents' knowledge about raising their children and incorporating new knowledge about positive parenting practices into daily interactions with families, building on parents' natural motivation to learn more. A report by the National Academies of Sciences, Engineering, and Medicine found a number of parenting practices that are associated with positive child outcomes, including:

- Contingent responsiveness (“serve and return”)—adult behavior that occurs immediately in response to a child’s behavior and that is related to the child’s focus of attention, such as a parent smiling back at a child;
- Demonstration of warmth and sensitivity;
- Routines and reduced household chaos;
- Shared book reading, talking, and singing with children;
- Practices that promote children’s health and safety—in particular, receipt of prenatal care, breastfeeding, vaccination, ensuring children’s adequate nutrition and physical activity, monitoring, and household/vehicle safety; and
- Use of developmentally appropriate discipline.

A parenting intervention
is a structured set of activities for children’s primary adult caregivers intended to positively influence parenting behaviors and achieve positive outcomes for children. These interventions can be implemented over a specific time period and offer a standardized manual for staff delivering the intervention.

Programs should reinforce these practices during everyday interactions with families. Programs should also implement structured parenting interventions to continue building adult capacity in implementing these practices. These parenting supports are important for all families, but may be especially critical for families struggling with alcohol or substance misuse given that children may be more likely to demonstrate developmental delays or disabilities. Positive parenting may be more difficult with these children and when adult wellness is disrupted. Foster families or extended family caring for children who have been affected should be supported for similar reasons. Programs should partner with families to identify the appropriate intervention that meets their unique needs. Given that contextual stressors can interfere in program participation, programs should ensure they have family supports in place, including child care, transportation, and meals, for participating families. HHS' Compendium of Parenting Interventions includes information for many currently available evidence-based parenting interventions. It also includes guidance on how to select, implement, and modify interventions to be more appropriate for the population being served (National Center for Parent, Family, and Community Engagement, 2015).

Case Study: Positive Indian Parenting at the South Puget Intertribal Planning Agency

Located in western Washington state, the [South Puget Intertribal Planning Agency](#) (SPIPA) was formed in 1976 as a 501(c) (3) tribally chartered intergovernmental agency. The SPIPA consortium includes five tribes: the Chehalis, Nisqually, Shoalwater Bay, Skokomish, and Squaxin Island. SPIPA provides direct services, planning, and technical assistance to each tribe and to eligible Native Americans residing within the SPIPA service area. SPIPA is a recipient of an ACF Tribal Home Visiting grant, through which it created the Healthy Families Project.

The goal of SPIPA's Healthy Families Project, which uses the [Parents as Teachers](#) (PAT) home visiting model, is to improve the health and wellbeing of Native American families and children through the development and provision of a comprehensive, culturally appropriate home visitation service delivery program that will increase levels of child and family development and increase the use of traditional Native American parenting skills. To meet these goals, SPIPA supplemented its PAT model with the [Positive Indian Parenting](#) (PIP) curriculum.

PIP draws on historic Native child-rearing practices related to storytelling, cradleboards, harmony, lessons of nature, behavior management, and the use of praise. It also addresses the historic impact of boarding schools, intergenerational trauma and grief, and forced assimilation on parenting. PIP is strengths based, conveying a message that AI/AN ancestors' wisdom is a birthright for Native parents. SPIPA's hope in implementing PAT and PIP as part of the Healthy Families Project is that Native American parents who learn and consistently implement traditional Native American parenting skills will gain access to the rich resources and cultural support within the tribal community, by engaging a traditional Native American model of child and family development.

A number of parenting interventions have published evidence showing that the intervention leads to positive parenting and child outcomes, but few of these have been tested in tribal settings or with AI/AN populations (National Center for Parent, Family, and Community Engagement, 2015). Nonetheless, some of these interventions have much potential for use with AI/AN families. For example, Positive Indian Parenting (PIP) is one parenting intervention developed by and for AI/AN families (see box, "Positive Indian Parenting at the South Puget Intertribal Planning Agency"). PIP is a

curriculum consisting of eight sessions that provides a practical and culturally-specific training for AI/AN parents to explore the values and attitudes expressed in traditional AI/AN child-rearing practices and apply those values to modern parenting. It has been used broadly in tribal communities and settings, although evidence of its effectiveness has not been published in peer-reviewed journals (National Center for Parent, Family, and Community Engagement, 2015).

F. Screen all children for early identification of strengths and needs.

All children need support in the early years to make sure they develop in a healthy way. Just as hearing and vision screenings assure that children can hear and see clearly, developmental and behavioral screenings assure that children are making developmental progress in areas such as language, social, or motor development. Monitoring for developmental progress is critical whether or not children have been diagnosed with a disability such as FASD. It is especially important for children who may be at developmental risk, such as children who may have NAS or a history with NAS, but are not currently receiving early intervention services.

As such, early childhood programs in tribal communities should prioritize developmental and behavioral screening and follow-up for all children. Developmental and behavioral screening can help determine if a child's development is on track for his or her age, needs to be followed more closely, or if he or she needs more in-depth evaluation. For children with disabilities, screenings can help ensure that programs do not miss a developmental issue that is not necessarily influenced by their disability or that is not currently being addressed by their services and supports. The screening can also provide valuable information to both teachers and families on supporting children's holistic development, across settings. Screening requires the availability of valid, reliable, and feasible research-based screening tools that detect concerns consistently and in a way that is practicable in a community-based setting such as an early childhood classroom or home (see box, "Considerations for Finding the Right Screening Tool").

Screening is especially important in tribal communities. Though little research literature exists on the early development of AI/AN children, in particular, the prevailing literature suggests that AI/AN children are as likely, if not more likely, to be living in environments that put them at risk for developmental delays or behavioral challenges (Mitchell et al., 2011; Marks and Garcia Coll, 2007; Sarche et al., 2008). There are many reasons why screening can be challenging in tribal communities, despite its importance. There may be an absence of effective systems or infrastructure to support and facilitate screening; lack of training in tool administration and support

Considerations for finding the Right Screening Tool

- ✓ Ages: What age groups do I serve and what screening tools are made for those ages?
- ✓ Time: How much time does it take to use this screening tool? Which tool is practical within a child care or Head Start program?
- ✓ Cost: What is the cost for the screening tool and its ongoing use within early care and education programs?
- ✓ Training: Is there training required to use this screening tool? How much training is required? What type of training is recommended?
- ✓ Languages: Does the screening tool need to be available in different languages to fit the needs of the families I serve?
- ✓ Culture: Is it culturally appropriate?

for families through the screening process; a dearth of appropriate community services to refer families for follow up such as early intervention or substance abuse treatment and recovery; an uncertainty about how to talk with parents and families about the need for screening and/or possible concerns or issues identified; concerns about confidentiality and privacy or a fear of stigma on the part of parents; and a lack of culturally appropriate, reliable, and valid measures for surveillance and screening.

Though there are challenges to screening Native children, it is still critical to implement and sustain program- and community-wide screening and response initiatives in tribal settings. There are many tools and resources that can help programs facilitate screening and follow-up, including Birth to 5: Watch Me Thrive! and CDC's Learn the Signs; Act Early (see Resources). As early childhood programs in tribal communities enhance their use of screening, support, and follow-up, programs must recognize that many screening tools are (by definition) designed to detect risk – and as such may create deficit-focused “habits of thought” among providers and families. Staff should be encouraged to balance their risk-based inquiry with an intentional focus on celebrating developmental milestones, as well as building habits and attitudes that surface and elevate child, family, community, and cultural strengths.

G. Partner with early interventionists, special educators, and other specialized professionals to ensure that children affected by alcohol or substance exposure receive individualized and consistent supports.

Children who have been diagnosed with a FASD or who have been affected by exposure to substances may be eligible for early intervention services from birth until age three (and potentially beyond) and preschool special education services from age three to school-entry. Early interventionists and special educators have specialized skills to help support the development and growth of children with disabilities and delays. Early childhood programs should partner with children's early interventionists, special educators, and other specialized service providers to ensure that infants and young children receive the supports they need, in an inclusive setting, while they are in their early childhood program. Specialists can also help build the capacity of early childhood providers in delivering individualized supports to young children affected by alcohol or substance exposure. Early interventionists and other specialists will need to employ developmental, strengths-based and reflective approaches consistent with those used by early childhood educators to build strong partnerships with parents.

H. Pilot or expand culturally appropriate and relevant infant and early childhood mental health consultation, reflective supervision, and two-generation mental health and wellness supports.

Infant and early childhood mental health consultation (ECMHC) and professional development practices like reflective supervision are promising approaches in tribal communities and may be especially relevant to the needs of families struggling with issues of alcohol and substance misuse and the staff who support them.

ECMHC is an approach for promoting the social, emotional, and behavioral health of infants and young children, by providing support to those who care for them. ECMHC in early childhood settings typically involves establishing a warm and positive climate through supportive policies, coaching providers on how to support children's social, emotional, and behavioral development, aligning classroom teaching and learning practices with these supports, conducting developmental and behavioral screenings, strengthening family-provider relationships, and connecting children,

families, and staff to additional services and supports as needed. Each of these are important supports for all children, families, and programs, but may be especially helpful to programs that serve families who are facing alcohol or substance misuse issues and children who have been exposed to such substances in utero.

Like all interventions and approaches, programs should ensure that the ECMHC is culturally responsive and appropriate to meet the needs of the families they work with. Though preliminary, ECMHC has been successfully implemented in tribal communities through Project LAUNCH (see box, “Project LAUNCH – Ili Uusim Hiapsi”). Given the early stage of ECMHC in tribal communities, it is critical to invest in, pilot, and better understand how these practices can best be supported in tribal contexts to determine the extent of their potential, and the need for and possible effectiveness of adaptations – possibly in partnership with researchers to measure effectiveness. In particular, pilots should examine whether the same models and principles of mental health consultation and reflective supervision are applicable and effective in tribal communities, whether people would be comfortable with these approaches, how they compare with traditional reflective practices, whether qualifications for mental health consultants and reflective supervisors should be different in tribal settings, what the role of elders and cultural leaders should be, and how these practices would fit in with other parts of tribal systems of care.

I. Restore or revitalize traditional cultural practices that support children’s social and emotional development across all services and strategies.

Connected by spirituality, traditional cultural practices are used in all aspects of life, including raising and educating children. Early childhood programs in tribal communities can partner with tribal leaders, elders, and cultural leaders to offer culturally-grounded practices that support children’s development in early childhood programs. These can include using Native languages, and incorporating the community’s songs and stories. Local elders and cultural specialists should be invited into the program to ensure that these practices are used appropriately and respectfully, and that indigenous worldviews inform classroom practice and family engagement activities. HHS and the U.S. Department of Education released a [Policy Statement on Better Supporting Dual Language Learners in Early Childhood Settings](#), including children from AI/AN communities, which includes a set of considerations for tribal revitalization, maintenance, preservation, and restoration.

Family support efforts in AI/AN settings are most likely to be effective if they build on traditional cultural strengths and incorporate indigenous worldviews and ways of knowing (Bigfoot, 2008; Barlow, et al., 2013). Culturally-grounded family protective factors may include taking pleasure in a child’s actions and giving praise, treating children as special and valuable members of the family and community, setting clear limits and expectations that define acceptable behavior for a child, and exhibiting family sobriety and encouragement for a sober life (Mohatt, et al., 2007).

Project Linking Actions for Unmet Needs in Children's Health (LAUNCH)-Ili Uusim Hiapsi

The Project LAUNCH-Ili Uusim Hiapsi (IUH) program is a division of the Pascua Yaqui Tribal Health Department's Sewa Uusim Community Partnership. Since receiving the Project LAUNCH grant in 2012, the IUH program has focused on promoting family wellbeing and healthy development of young children through developmental and social and emotional screenings and assessments, community education and training, improved care coordination, parenting support, home visiting services, and Early Childhood Mental Health Consultation. Some of the accomplishments and highlights of IUH are:

- Parent Cafecitos (a Parent Café model) to increase parent engagement, build protective factors, and promote peer-to-peer learning. The IUH-Parent Cafecitos are based on the principles of adult learning and family support and are a gateway to providing parent leadership opportunities.
- Increased referrals through the Community Health Nursing programs, thus increasing the community's awareness and knowledge of supports aimed at young children and their caregivers.
- A strong partnership with the Tribal Head Start program which has resulted in the development of classroom based early childhood mental health supports, workforce development for staff, and coordination between Head Start and other services provided to families. This includes regular summer enrichment programs.
- Family Navigators who support families with developmental screenings, referrals, and care coordination following a "wraparound model".
- Bringing a home visiting program to the community that has an emphasis on social emotional development and has allowed for more families to access additional supports and resources.
- Community engagement and outreach events focused on social emotional development and parenting, such as "Mommy & Me" activities for children 0-3 years old and their caregivers conducted by home visitors, and "Community Baby Showers" for expectant families that are also used as an opportunity for community education on a variety of topics.

The IUH program has established partnerships and collaboration across Tribal departments, thus creating early-childhood focused connections between behavioral health and community health, early care and education and Women, Infants, and Children (WIC). The program has also partnered with non-tribal entities to improve supports for families, such as local public schools and the Regional Partnership Council of Arizona's First Things First.

J. Support staff wellness.

Early childhood programs should attend to staff wellness. Child wellness is dependent on adult wellness, which includes primary caregivers, but also includes early childhood providers who spend time with children and families. Early childhood providers have stressful jobs, often receive low compensation, and in many instances, face many of the same challenges as the families who they serve. High levels of stress and adversity can affect self-regulation and the ability to co-regulate, and more broadly, affects the ways in which adults interact with children. Early childhood programs should ensure that staff have access to health and mental health supports, have fair working conditions with breaks, earn fair compensation, and have paid sick leave. In addition, supervisors

and coaches, such as early childhood mental health consultants, should ensure that staff have the ability to reflect on the emotional effects of their work experiences. Early childhood mental health consultation, of which reflective supervision and self-reflection are important parts, has been found to decrease staff stress and turnover.

K. *Facilitate an organizational “culture of continuous quality improvement.”*

Continuous quality improvement (CQI) is a learning process focused on improving results and encouraging innovation rather than assigning blame or creating fear (Radawski, 1999). It depends on mutual respect, cooperation, encouragement, and open communication across staff teams and organizations (Michigan Public Health Institute, 2012) (See box on “Building CQI Capacity to Improve Tribal Home Visiting”). By fostering a culture of continuous quality improvement in their organizations, early childhood programs in tribal settings can reinforce the non-stigmatizing ways that they work with AI/AN families. Engagement with tribal and community leaders is critical to ensure that CQI efforts are supported and sustained.

Promising Practice: Building CQI Capacity to Improve Tribal Home Visiting

The [Tribal Home Visiting Evaluation Institute \(TEI\)](#) is a technical assistance provider for Tribal Maternal, Infant, and Early Childhood Home Visiting grantees providing support in program evaluation, performance measurement, dissemination and CQI. To begin their CQI work, Tribal Home Visiting grantees attended a 3-day intensive regional workshop for a hands-on introduction to CQI. Grantee teams learned about CQI concepts and tools and begin a CQI project. Grantees generally brought their entire teams, including home visitors and data staff, to the workshop. Grantees selected a topic and measures for their CQI project based on their home visiting program goals. Common topics included the following:

- Family engagement (e.g., family referrals, enrollment, retention, completed visits, participation in group meetings)
- Screenings (e.g., intimate partner violence, maternal depression, substance abuse, child developmental delay, basic family needs)
- Referrals (i.e., whether positive screenings result in accurate and timely referrals for appropriate services)

Grantees continued their projects when they returned to their communities. TEI followed up the regional workshops with quarterly Community of Learning webinars that helped grantees share their CQI work and learn about effective improvement approaches from peers and experts in the field.

Recommendations for Tribal and Community Leaders

Tribal and community leaders, including elders, spiritual leaders, and traditional healers, play an essential role in setting priorities and expectations, focusing investments, and influencing the future direction of their communities. The following recommendations flow from our understanding of leaders’ commitment to tribal sovereignty and self-determination and their position as decision-makers.

A. Invest in prevention strategies and incorporate a trauma-informed approach.

It is widely acknowledged that prevention of chronic diseases, health, and substance misuse challenges is vastly preferable to treating these challenges later – both for individuals and communities. Investments in prevention across the life span complement and support treatment and care. Prevention policies and programs can be cost-effective, reduce health care costs, and improve productivity (CDC, 2014). Investment in prevention and health, mental health, and behavioral health promotion activities, for all tribal members, from infants to elders, is critical.

Prevention efforts focused on alcohol and substance misuse and ensuing conditions in young children, should extend across the health, early childhood, education, and social services sectors. Prevention and promotion for young children begins in pregnancy and before, with access to treatment for health, mental health and substance misuse challenges. Once a baby is born, prevention and promotion continue with universal developmental and behavioral screening, supports for parents' wellness and in their role as parents, and access to healthcare and high-quality early childhood services. Tribal leaders can prioritize expanding access to high-quality early childhood programs, including both early education programs and home visiting programs, and ensure that programs have the resources they necessary to support the children and families they serve.

For adults, prevention efforts should engage the health, behavioral health, and social services sectors and begin with access to preventive health and mental health care. Preventive efforts to address alcohol and substance misuse in pregnancy and in parents and caregivers of young children should include a public education component to raise awareness of the general public as well as the provider community – including health, behavioral health, mental health, early childhood, and other providers – of the effects of exposure to adult alcohol and substance misuse on fetuses, infants, and young children. It is critical that public awareness campaigns about alcohol and substance misuse challenges are non-judgmental, de-stigmatizing and hopeful so that affected individuals feel encouraged to seek help rather than to hide their problems.

Tribal leaders can ensure that all strategies are embedded in culture, language, and community strengths and take a trauma-informed approach (see box, “Head Start Trauma Smart and the Menominee Nation”).

Promising Practice: Head Start Trauma Smart and the Menominee Nation

Head Start Trauma Smart helps preschool children and the adults who care for them calmly navigate difficult life challenges by pairing practical tools in the classroom with coping strategies from the early childhood, health and mental health fields. Created by the [Crittenton Children's Center Trauma Smart](#), instructs caretakers to recognize and address mental health problems; actively includes parents in their child's school experience; and improves the work environment for teachers and school personnel.

Trauma Smart is a systemic practice model that addresses the aftermath of violence and trauma within the context of a natural environment – Head Start classrooms. Trauma Smart serves as a “pause” and “reset” button so that all children can enter kindergarten prepared to succeed socially and academically. Tailored to community and classroom needs, the model aims to create a community where all the people who interact with children – parents, grandparents, teachers, administrators, school bus drivers and ancillary school staff – are prepared to spot the signs of trauma and help kids cope. It is a multi-generational community approach designed to align school and home environments where children have high-quality learning opportunities. The model provides children and adults with specific strategies and tools to develop self-care techniques and build personal and collective resilience. The model is currently provided in Head Start preschool programs in 26 counties in the Kansas City metro area and across Missouri, and includes around 3,200 children annually.

It has also been implemented in the [Menominee Nation](#) as part of their Safe Schools Project. Addressing both historic wounds and more recent suffering, members of the Wisconsin tribe are using this trauma-informed care model in its social and behavioral health services. This has dramatically changed life for its members. According to Ryan Coffey, an elementary school teacher and counselor, trauma informed care “doesn't take a lot of planning. It doesn't take extra time. It's about getting to know your kids.” The approach's success is among the reasons the Menominee Nation was awarded a Robert Wood Johnson Foundation Culture of Health Prize in 2015.

B. Expand access to mental and behavioral health supports in healthcare facilities.

While prevention efforts are critical, so is access to treatment for individuals already affected by alcohol and substance misuse and mental health difficulties. A 2005 Government Accountability Office (GAO) study of diverse IHS-funded facilities found many gaps in medical specialty and ancillary services such as behavioral health. When such services did exist, they often were not accessible because of factors such as the amount of waiting time between the call to make an appointment and the delivery of a service, travel distances to facilities, or a lack of transportation (GAO, 2005). Depending on community needs, tribal leaders may consider prioritizing and expanding access to mental and behavioral health services in existing health facilities and in other settings in the community that serve children and families.

These settings can have specialized programs to support pregnant women and families who are struggling with alcohol and substance misuse. Alcohol and substance misuse issues cannot be effectively treated unless their other mental health challenges are treated as well. In 2016, the Substance Abuse and Mental Health Services Administration developed *Advancing the Care of Pregnant and Parenting Women with Opioid Use Disorder and their infants: A Foundation for Clinical Guidance*. This document includes a comprehensive review of existing research by expert

professionals and reflects stakeholder input. The document provides key recommendations for women of reproductive age, pregnant women, peripartum women, breastfeeding women, parenting women, and infants.

C. Support family-centered, cross-tribal program collaboration.

In many communities, including tribal communities, programs that support the health and development of young children and families exist in silos. For example, even within health care, obstetrics, pediatrics, infant mental health, adult mental health and substance abuse treatment often operate in isolation from each other. These and other silos, by definition, mean that each individual program or sector develops and implements its own strategies to meet identified needs – often without leveraging partnerships to maximize their impact. This can be especially problematic for families managing alcohol and substance misuse issues, given that the parent’s wellness is so intertwined with the child’s wellness, and that alcohol and substance misuse are so often associated with mental health challenges and medical conditions such as those that cause chronic pain. Given the multifaceted issues associated with alcohol and substance misuse and the effects on young children, it is critical that tribal and community leaders recognize the potential of cross-sector partnerships across health, mental health, behavioral health, child welfare, early childhood, and home visiting programs in tribal communities.

Leaders have the ability to encourage and support agencies to connect with each other on the ground level – with staff interactions between those who serve adults and pregnant women, to those who serve young children. Across agencies, service providers will find it easier to collaborate with each other when they share the same non-judgmental, strengths-based approach to families struggling with alcohol and substance misuse. This can improve the experience of AI/AN children and families in navigating existing resources and achieving success, and to strengthen the ability of the overall system to respond to needs. Efforts like the TELI (see box, “Tribal Early Learning Initiative at the Choctaw Nation of Oklahoma”) and Project LAUNCH (see box, “Project LAUNCH-Ili Uusim Hiapsi”) demonstrate some of the concrete benefits of partnership across programs. Tribal leaders can play a role in supporting and deepening these partnerships and ensuring that they reflect and build on tribal values and strengths.

D. Sustain and strengthen traditional cultural values and practices.

Tribal communities can use traditional practices and ensure their long-term sustainability by ensuring that the next generation understands those practices. Communities can consider ways to implement these practices alongside other evidence-based practices as a way to enrich children’s development. Such traditional practices and embedded cultural values can be beneficial to families recovering from alcohol and substance misuse, and may have buffering effects on young children suffering from in-utero exposure to alcohol or substance. In doing so, communities can strengthen and sustain culturally-based practices, honor traditional ways of knowing, build tribal capacity and move toward greater tribal sovereignty, autonomy, and self-determination. In some instances, strong and effective AI/AN practices may have been eroded or disrupted by historical and political forces, and as a result might benefit from revitalization efforts to renew their positive effects.

Tribal leaders and community members interested in language revitalization, restoration, maintenance and preservation efforts can reference HHS and the ED’s recent [Policy Statement on Better Supporting Dual Language Learners in Early Childhood Settings](#) for a set of considerations that can be taken and resources to support implementation.

Case Study: Tribal Early Learning Initiative at the Choctaw Nation of Oklahoma

The [Tribal Early Learning Initiative \(TELI\)](#) began in 2012 as a partnership between ACF and American Indian tribal entities with AI/AN Head Start/Early Head Start, Tribal Child Care Development Fund (CCDF), and Tribal Maternal, Infant, and Early Childhood Home Visiting (Tribal MIECHV) programs. The purposes of the TELI are to:

- Support tribes to coordinate tribal early learning and development programs.
- Create and support seamless, high-quality early-childhood systems.
- Raise the quality of services to children and families across the pregnancy-to-kindergarten-entry continuum.
- Identify and break down barriers to collaboration and systems improvement.

As a TELI grantee since 2012, the [Choctaw Nation of Oklahoma](#) has worked across its Chahta Inchukka and Chahta Vlla Apela Tribal MIECHV Programs, Child Care Assistance, Child Care Development Program, Early Head Start, Head Start, and Support for Expectant and Parenting Teens programs to improve outcomes for young children and their families. Due to their large land base, many of the Choctaw Nation early childhood programs were not collaborating with one another at the start of the TELI and have built awareness and relationships through the initiative.

As a group, the programs recognized the high number of children with special needs in the community and determined that joint professional development opportunities on this topic would be helpful. Since 2014, the programs therefore launched the annual Choctaw “Day of the Young Child” which emerged as a way to bring staff together and to raise community awareness about child development and resources available to families. The 2015 event also kicked off a year of autism awareness activities, including training on autism for program staff and local events for families at Head Start and child care centers. Presentations were made later that year by two nationally known speakers: Temple Grandin, a Colorado State University professor and autism advocate, and her mother, Eustacia Cutler.

Joint staff trainings across programs have been well-received. “One thing that I really like about bringing staff together is that we have a face we can put with the name and feel more comfortable reaching out to that person,” said Brandi Smallwood, Chahta Inchukka Tribal MIECHV Program Director. “We know who to call to refer families and can work hand-in-hand with them.” “I feel like we’re talking the same language, and our staff is also,” said B.J. Robinson-Ellison, Director of Early Head Start. “We’re coming together as one early childhood system so our team can see the unity of these programs and that we’re going to support one another.”

E. Support and invest in research and evaluation at the tribal and community level.

While many proven and promising approaches exist for supporting the social and emotional health and well-being of young children and families, there is a continued need for identification of strategies that are effective with AI/AN children and in tribal communities, that build on cultural strengths and AI/AN ways of knowing, and that revitalize effective traditional AI/AN approaches for advancing children’s healthy development and learning.

Tribal and community leaders have a critical role in ensuring that research and evaluation is prioritized, and done in a way that honors tribal sovereignty, is culturally and scientifically rigorous, and advances the health and well-being of Native people. Leaders can build local tribal capacity to conduct high-quality research and evaluation or can choose to partner with academic institutions, including Tribal Colleges and Universities. In either case, leaders have the ability to own and guide the evaluation design, implementation, interpretation and dissemination process.

There are large gaps in understanding what specific interventions and strategies can support families struggling with alcohol and substance misuse, and their young children who may be affected by in-utero substance exposure and FASD. By engaging in this research on their own terms, tribal communities can contribute to the knowledge base of interventions developed uniquely to meet the needs of AI/AN people with these specific needs. The knowledge gained may not only be applicable to other tribal communities, but may be extended to support cities and states around the country who are struggling with similar issues.

Recommendations for Federal, State, Local, and Philanthropic Partners

A number of stakeholders can play an important role in supporting the health and well-being of AI/AN people and tribal nations, including federal, state, local, and philanthropic leaders in early childhood development, public health, child welfare, and maternal and child health.

A. Federal, state, and local efforts to support pregnant women, families, and young children affected by alcohol or substance misuse should include special considerations for AI/AN individuals.

About 78% of AI/ANs live outside of tribal reservations in states and communities across the country, with most living in urban areas (U.S. Census Bureau, 2011). AI/AN communities and cultures are diverse and have many cultural strengths that are important protective factors for young children affected by alcohol and substance exposure and their families. Federal, state and local prevention efforts and efforts to support affected families should be culturally responsive and build on the unique cultural strengths and traditions of AI/AN people. Local officials should consult with tribal leaders, including urban Indian community partners, to ensure that this happens.

B. Include tribal voices in local, federal, and statewide efforts and establish or expand upon meaningful tribal consultation policies and practices.

Just as the federal government and tribal nations have a government-to-government relationship that recognizes and supports tribal sovereignty and self-determination, states have a government-to-government relationship with the tribes that lie within their borders. Because so many important funding streams that can support AI/AN child and family health and well-being go directly to states, it is important to raise expectations for states to engage in meaningful consultation with tribes that results in adequate resources going to tribal communities, including both rural and urban settings. Ensuring these adequate and sustainable resources depends on strong, trusting state-tribal relationships. It also depends on intentional consultation with tribal leaders to co-identify challenges, strengths, priorities, and solutions. State leaders who take the time to engage in such consultation and relationship-building, and who reach out to tribal leaders as they develop statewide initiatives that impact diverse communities, will often find their efforts rewarded with stronger initiatives and more efficient and effective allocation of resources. Local and foundation leaders, too, have an opportunity to engage tribal stakeholders in their initiatives; tribal and

community leaders' successes and struggles often contain lessons for new initiatives that can improve their likelihood of success.

C. Recognize and support tribal sovereignty.

As federal entities, states, localities, and foundations better engage tribal leaders and communities, it is important to explicitly structure partnerships and grants, including those that address the needs of pregnant women and young children affected by alcohol and substance use, to incorporate flexibility and respect for tribal sovereignty and self-determination. For example, agreements may need to incorporate additional time for engagement of tribal community members and stakeholders in processes such as needs assessments and planning. Agreements may need to recognize the challenges of providing services in tribal settings – such as an understandable trust deficit, justified by past negative experiences, that often exists whenever there is a new service offered. It may take tribal communities longer to reach a full caseload, or perhaps a smaller caseload is required because of travel distances or the high need of families. Importantly, partners must recognize that some tribal communities might not fully embrace mainstream public health strategies because they are trying to build on cultural knowledge and traditional teachings. The process of restoring and revitalizing these traditional practices for the current generation and the next, or developing cultural adaptations, takes time and input from cultural leaders, elders, and community leaders, and cannot be rushed.

D. Support more direct funding to tribal entities.

As mentioned above, many important funding streams that could support AI/AN children and family health and well-being are not directly available to tribes, tribal organizations, or urban Indian organizations. Where funding streams are available directly to tribal entities, the resources often come nowhere close to meeting the need. Therefore, it is important for all partners to support more direct funding directly to tribal communities and for an increase in resources to meet the need, without detracting from the needs of other groups. Just as partners can support more direct funding streams to tribal communities in existing and new funding streams, they can also play a role in advocating for funding proportional to the need in AI/AN communities. This includes Indian Health Services funding that is on par with the funding to beneficiaries of Medicare, Medicaid, or the Veteran's Affairs health system.

E. Build cultural competence and responsiveness in programs and systems.

It is important for all partners to build cultural competence and responsiveness in programs and systems that affect Native children and families. Failure to properly address cultural differences increases stress and creates and maintains mistrust and other potential conflicts between service providers and potential clients, further contributing to low quality of care and poor health outcomes. Thus, delivering culturally competent services remains a goal and a highly promising approach to promoting positive outcomes among culturally, racially, and ethnically diverse groups and to ultimately reducing health disparities (Calzada & Suarez-Balcazar, 2014).

A recent brief from the ACF Office of Planning, Research and Evaluation (OPRE) lays out approaches to building organizational cultural competence, arguing that building this competence depends on: 1) a cognitive component that emphasizes critical awareness (i.e., awareness of one's biases) and knowledge (i.e., understanding of a specific cultural group's history, religion, historical context and beliefs) relevant to the health and well-being of diverse children and families; 2) a behavioral

component that emphasizes the ability to put skills into practice to build trust and effectively communicate with and serve diverse children and families; and 3) an organizational component that emphasizes contextual issues and support for culturally competent practices from an organization that is committed to diversity and innovation to meet the needs of diverse children and families (Calzada & Suarez-Balcazar, 2014).

The AI/AN Culture Card: A Guide to Build Cultural Awareness is an example of a resource that can be used to build critical awareness and knowledge and set the stage for changing individual behaviors and organizational structures to be more culturally competent and responsive when working with Native people and communities (SAMHSA, 2009). It covers topics such as tribal sovereignty, regional differences, cultural customs and identity, spirituality, communications styles, the role of veterans and the elderly, and health disparities.

F. Invest in and support research and evaluation activities in tribal early childhood programs.

Federal, state, local, and philanthropic leaders are well-poised to prioritize, fund, and support research and evaluation activities that involve tribal early childhood programs and communities. Given the importance of continued knowledge building to better serving AI/AN children and families, these leaders should partner with tribal communities, early childhood programs, and researchers on research and evaluation efforts that build tribal capacity, support bi-directional learning across tribal communities and researchers, and generate important new evidence.

For historical, ethical, and other reasons, tribal communities must determine how research is designed and conducted within those communities. Many have established their own research protocols that must be respected. Research has generally been imposed on tribal communities from the outside with little benefit to communities themselves (Sahota, 2010). Funders and researchers should work in partnership with tribal communities across diverse contexts and engage tribal community members in defining, designing, implementing, analyzing, interpreting, and communicating about research findings (See *A Roadmap for Collaborative and Effective Evaluation in Tribal Communities*, Tribal Evaluation Workgroup, 2013).

There are many areas of study that could provide critical insight and benefits to tribal nations as they seek to promote the health and well-being of young children and their families- including and especially those struggling with alcohol and substance misuse issues, including:

- Developing and validating developmental and behavioral screening tools for use in tribal communities.
- Conducting effectiveness, efficacy, and implementation studies of early childhood programs and strategies, and their adaptation in tribal settings.
- Prioritizing the tribally-driven development of practice-based and culturally-based evidence.
- Conducting descriptive studies of early childhood programs in tribal communities.
- Including greater tribal community representation in the design and implementation of national studies and engaging with tribal partners to conduct studies in culturally sensitive ways that build tribal capacity.
- Investing in better data that document AI/AN children and families' strengths and needs and the extent to which existing services build on those strengths and meet those needs.

Conclusion

Tribal communities and populations have incredible resilience in the face of challenges, innumerable cultural strengths, and great capacity and resources to support the healthy development of young children and families. AI/AN families can provide children with a strong foundation for learning about who they are, who their people are, where they come from, and where they are going. These cultural assets can protect AI/AN children against developmental challenges (Jumper-Reeves, et al., 2014; Pewewardy, 2002; Tsethlikai, 2011; Chandler & Lalonde, 1998). Like many cities and states around the country, tribal communities are working to address the effects of alcohol and substance misuse on pregnant women, families, and young children. Early childhood programs can play an important role in helping address this issue and can support affected children and families by implementing the outlined recommendations. With support from tribal leaders and in partnership with federal, state, local, and philanthropic leaders, these efforts can serve to prevent and reduce the effects of exposure to adult alcohol and substance misuse on young Native children.

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U.S. Department of Health and Human Services Resources (HHS)

Birth to 5: Watch Me Thrive! is a coordinated federal effort to encourage healthy child development, universal developmental and behavioral screening for children, and support for the families and providers who care for them.

Administration for Children and Families (ACF)

Child Care and Development Fund (CCDF) is a partnership between the federal government and states, tribes, and territories to promote family economic self-sufficiency and to help children succeed in school and life through affordable, high-quality early care and afterschool programs. CCDF improves the quality of care to support children's healthy development and learning by supporting child care licensing, quality improvements systems to help programs meet higher standards and support for child care workers to attain more training and education.

Early Head Start Child Care Partnerships allow new or existing Early Head Start programs to partner with local child care centers and family child care providers serving infants and toddlers from low-income families. Partnerships support working families by providing a full-day, full-year program so that children have the healthy and enriching early experiences they need to realize their full potential. Comprehensive services are provided that benefit children, families, and teachers, including health, developmental and behavioral screenings; higher health, safety and nutrition standards; increased professional development opportunities for teachers; and increased parent engagement opportunities.

Early Head Start/Head Start is a federal program that promotes the school readiness of children ages birth to five from low-income families by enhancing their cognitive, social and emotional development. Over a million children are served by Head Start programs every year, including children in every U.S. state and territory and in American Indian and Alaskan Native communities. Since 1965, nearly 30 million low-income children and their families have received these comprehensive services to increase their school readiness. Head Start programs offer a variety of service models, depending on the needs of the local community.

National Center for Early Childhood Health and Wellness is administered in partnership with the **Maternal and Child Health Bureau** and advances best practices for linking health and early childhood education systems. The Center's work includes, but is not limited to, providing support on topics such as medical and dental home access; health promotion and disease prevention; emergency preparedness and environmental safety; trauma and toxic stress; developmental, behavioral, vision and hearing screening; and nutrition.

National Center for Early Childhood Development, Teaching, and Learning supports family well-being, effective family and community engagement, and children's school readiness, including transitions to kindergarten. The Center's work will include, but is not limited to, providing T/TA on staff-family relationship building practices that are culturally and linguistically responsive; integrated and systemic family engagement strategies that are outcomes-based; consumer education, family leadership, family economic stability, and individualized support for families facing adversity.

National Center for Parent, Family, and Community Engagement advances best practices in the identification, development, and promotion of the implementation of evidence-based child development, teaching and learning practices that are culturally and linguistically responsive and lead to

positive child outcomes. Its emphasis is across early childhood programs and supports strong professional development systems. The Center's work will include, but is not limited to, professional development for the infant/toddler and preschool workforce; evidence-based curriculum; early learning standards; effective transitions; screening and assessment; culturally and linguistically age appropriate practices; enhancing teacher/child interactions; supporting networks of infant/toddler practitioners; supporting children with disabilities (part C and part B); and using data to improve practice.

[National Center on Tribal Child Care Implementation and Innovation](#) assists AI/AN Tribes and tribal organizations in their efforts to implement and administer the Child Care and Development Fund as well as increase the quality, affordability, and availability of child care. Targeted activities include a toll-free information and referral line; development and dissemination of materials; a peer learning and leadership network; national and regional webinars; and other on-site and distance learning events.

[Roadmap for Collaborative and Effective Evaluation in Tribal Communities](#) is a resource that can be used to create a shared vision for the future of Tribal child welfare evaluation and provide a common language for Tribal communities and evaluators as they improve evaluation practice. An overarching idea in the Roadmap is the concept of “growing our own,” with an emphasis on supporting the training and career development of Tribal members who are working to become evaluators and researchers.

[Tribal Early Learning Initiative](#) supports tribes in effectively coordinating and leveraging the Child Care and Development Fund, Head Start/Early Head Start, and Tribal MIECHV programs to enhance quality of services while targeting the needs of communities, children, and families. Grantees work to create and support seamless quality early childhood systems comprised of programs across the prenatal to kindergarten entry continuum.

[Tribal Maternal Infant and Early Childhood Home Visiting](#) provides grants to tribal organizations to develop, implement, and evaluate home visiting programs in AI/AN communities. The Tribal Home Visiting program is designed to develop and strengthen tribal capacity to support and promote the health and well-being of AI/AN families; expand the evidence-base around home visiting in tribal communities; and support and strengthen cooperation and linkages between programs that service AI/AN children and their families.

[The Tribal Evaluation Institute’s](#) mission is to help Tribal Home Visiting grantees gather and use information to improve the health and well-being of children and families. It provides technical assistance in program evaluation, performance measurement, continuous quality improvement, and dissemination. Their community-engaged approach builds capacity while honoring local and cultural strengths and practices. Together, they develop knowledge about home visiting in tribal communities and beyond.

[Relationships-Based Competencies](#): This resource outlines the knowledge, skills, and actions for staff and supervisors who work with families. It can assist programs in implementing strong family and community engagement. This resources can be used to understand the current knowledge and skills of staff and supervisors, develop staff orientation and professional development, create job descriptions, and develop partnerships with local community colleges and universities to support related academic opportunities for staff.

[Parent Connections to Peers and Communities](#): This resource is a research-practice brief focused on family connections to peers and the community. Programs can use this brief to learn more about family connections and implement promising practices and proven interventions.

Centers for Disease Control and Prevention (CDC)

[Behavioral and Education Therapies](#) can be important parts of treatment for children with FASDs. Although there are many different types of therapy for children with developmental disabilities, only a few have been scientifically tested specifically for children with FASDs.

[CHOICES: Preventing Alcohol Exposed Pregnancies](#) is an evidence-based intervention (i.e., based on activities that research has shown to be valid and effective) that helps women to reduce or stop drinking, use contraception (birth control) effectively, or both. CHOICES uses motivational interviewing to increase a woman's motivation and commitment to change. Participants in CHOICES decide which behavior to focus on to reduce their risk of an alcohol-exposed pregnancy. It includes two to four counseling sessions plus a contraceptive counseling session.



[Fetal Alcohol Syndrome Disorders \(FASDs\)](#)

- [Free FASD Brochures, Posters, Fact Sheets, and Training Guides](#)
- [FASD Information for Educators](#)
- [FASD Intervention Strategies](#)
- [FASD Training and Education](#)

[Learn the Signs, Act Early](#) program aims to improve early identification of children with autism and other developmental disabilities so children and families can get the services and support they need.

[Parenting Essentials](#) is a free online resource designed for parents of two to four year olds and addresses common parenting challenges, like tantrums and whining. The resource provides on things you can do to build a positive, healthy relationship. Skills focus on encouraging good behavior and decreasing misbehavior using proven strategies like positive communication, structure and rules, clear directions, and consistent discipline and consequences.

Health Resources and Services Administration (HRSA)

[Bright Futures](#)  provides recommendations for the top 10 areas of child development. Along with presenting the most up-to-date information on preventive screenings and services by visit, *Bright Futures* provides visit-by-visit guidance for health care providers. Through a collaborative of federal and state partners, the initiative develops curricula, training, guidance, and research; and produces [Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents](#) .

[Federal Home Visiting Program \(Maternal, Infant, and Early Childhood Home Visiting\)](#), administered in partnership with the [ACF](#), gives pregnant women and families, particularly those considered at-risk, necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn.

[National Organization on Fetal Alcohol Syndrome \(NOFAS\) National and State Resource Directory](#)⁹

⁹ Originally compiled by the Fetal Alcohol Education Program at the Boston University School of Medicine through a cooperative agreement with the Maternal and Child Health Bureau, HRSA, HHS.

Title V Maternal and Child Health Block Grant aims to improve the health and well-being of women (particularly mothers) and children. It funds 59 states and jurisdictions to provide children:

- Access to quality care, especially for those with low-incomes or limited availability of care
- An increase in health assessments and follow-up diagnostic and treatment services
- Access to preventive and child care services

Indian Health Services (IHS)

Telebehavioral Health Center of Excellence was developed through support from the IHS Division of Behavioral Health and a partnership with the University of New Mexico Center for Rural and Community Behavioral Health. TBHCE mission is to provide, promote, and support the delivery of high quality, culturally competent telebehavioral health services to AI/AN when they are needed. To accomplish this mission, TBHCE focuses on three areas: Clinical Services; Provider Education; and, Telehealth Support.

National Institutes of Health, National Institute on Drug Abuse (NIDA)

Principles of Substance Abuse Prevention for Early Childhood: A Research-Based Guide provides principles addressing the ways in which early interventions can have positive effects on development; these principles reflect findings on the influence of intervening early with vulnerable populations on the course of child development and on common elements of successful early childhood programs. An overview of child development from the prenatal period through age 8 and the various factors that either place a child at risk for later substance use or offer protection against that risk is also detailed. The Guide also includes common elements of early childhood interventions that target individual, family, school, and community precursors of drug use, abuse, and addiction as well as information on specific early childhood interventions for which NIDA has provided research support.

Substance Abuse and Mental Health Services Administration (SAMHSA)

AI/AN Culture Card: A Guide to Build Cultural Awareness intends to enhance cultural competence when serving American Indian and Alaska Native communities. Covers regional differences; cultural customs; spirituality; communications styles; the role of veterans and the elderly, and health disparities, such as suicide.

Behavioral Health Treatment Services Locator is a directory of mental health and substance abuse treatment facilities in the United States and U.S. territories

Center of Excellence in Infant and Early Childhood Mental Health Consultation helps communities support the success of the next generation by increasing access to evidence-based IECMHC.

Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders: Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers provides an overview of the extent of opioid use by pregnant women and the effects on the infant; evidence-based recommendations for treatment approaches from leading professional organizations; an in-depth case study, including ideas that can be adopted and adapted by other jurisdictions; and a guide for collaborative planning, including needs and gaps analysis tools for priority setting and action planning.

[Fetal Alcohol Spectrum Disorders Center for Excellence](#) is intended to assist people affected by FASD and their families, state and local agency administrators, and service providers. The website is designed to provide resources and information, to improve knowledge about FASDs, and to promote best practices. It also offers information to individuals, families, and communities affected by FASDs in an effort to improve quality of life. SAMHSA also has a **[Substance Abuse Treatment Facility Locator](#)**. This locator helps people find drug and alcohol treatment programs in their area.

[National Center on Substance Abuse and Child Welfare](#) (NCSACW) provides technical assistance on substance abuse issues in the child welfare population. Assistance is available to national, state, tribal, and local agencies and individuals. A key feature of NCSACW's efforts is assistance in developing the cross-system partnerships and practice changes needed to address the issues of substance use disorders among families in the child welfare system. These services are free. NCSACW is an HHS initiative and jointly funded by the SAMHSA Center for Substance Abuse Treatment and the Office on Child Abuse and Neglect within the Administration for Children & Families' Children's Bureau.

- **[Substance Exposed Infants In-Depth Technical Assistance Program](#)**. NCSACW provides in-depth technical assistance to strengthen the capacity of states and local jurisdictions to improve the safety, health, and well-being of substance exposed infants, and the recovery of pregnant and parenting women and their families. The 18-month initiative supports six state efforts to strengthen collaboration and linkages across child welfare, addiction treatment, medical providers, early child care and education systems. [Connecticut, Kentucky, Minnesota - with a focus on Tribal communities, New Jersey, Virginia, and West Virginia](#) participate in this initiative.

[National Resource Center for Mental Health Promotion and Youth Violence Prevention](#) offers resources and technical assistance to states, tribes, territories, and local communities to come together to prevent youth violence. Resources from Project LAUNCH and Safe Schools/Healthy Students are featured.

[National Child Traumatic Stress Network](#) (NCTSN) brings a singular and comprehensive focus to childhood trauma. NCTSN's collaboration of frontline providers, researchers, and families is committed to raising the standard of care while increasing access to services. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and dedication to evidence-based practices, the NCTSN changes the course of children's lives by changing the course of their care.

[Tribal Training and Technical Assistance Center](#) provides comprehensive, focused, and intensive training and technical assistance to federally recognized tribes and other AI/AN communities. It seeks to promote mental health and address and prevent suicide and mental and substance use disorders. The Tribal TTA Center's goal is to use a culturally relevant, evidence-based, holistic approach to support native communities in their self-determination efforts through infrastructure development, capacity building, and program planning and implementation.

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