CHAPTER 37

Child Care and Early Education as Contexts for Infant Mental Health

Allison Boothe Trigg
Angela W. Keyes

When considering infants and young children and their mental health, out-of-home child care for infants and young children must be taken into account. As many infants spend long periods of times being cared for outside of their homes, topics such as the quality of care a child receives, attachment to nonparental caregivers, and support of optimal social–emotional development of young children are key. In this chapter, we discuss these issues, along with methods of supporting infant and early childhood mental health when young children are cared for in early care and education settings.

Child Care in America

For more than 25 years, the number of children being cared for in out-of-home placements has increased considerably as maternal employment has become the norm rather than the exception for most U.S. families. According to the U.S. Census Bureau, in the early 1960s, only 14% of women were employed outside the home after giving birth. By 1975, this number increased to 37% (Laughlin, 2011). In 2013, 70% of mothers with children under 18 years of age worked outside the home, and 61.1% of these women had children under the age of 3 (United States Department Labor, 2017). Currently, in the United States, nearly 11 million children under the age of 5 are cared for in out-of-home placements each week, while their parents work. On average, these children spend 36 hours a week in child care, and 25% are in multiple arrangements when parents work both traditional and nontraditional hours (Laughlin, 2013).

Child care can be provided in a multitude of settings, such as Head Start and Early Head Start programs; publicly funded prekindergarten programs; private child care centers, including faith based programs; or other early childhood programs, family child care homes, and kith-and-kin care. Typically, early care and education centers provide nonresidential care for a fee. However, costs may be subsidized by public funding based on parents' income. They may be privately operated for profit by a chain or individual, or operated by nonprofit agencies, including churches, public schools, or government agencies. Programs are usually licensed by the state and are subject to regulations, as well as regular monitoring and oversight, sometimes at the federal level. One such federally funded program is overseen by the U.S. Department of Health and Human Services. Head Start, instituted in 1965, was designed to help break the cycle of poverty by providing children under the age of 5 from low socioeconomic status backgrounds with a comprehensive program to meet their emotional, social, health, nutritional, and psychological needs. Early Head Start

serves pregnant women, infants, and toddlers through early, continuous, intensive, and comprehensive services. Early Head Start programs are available to families until a child turns 3 years old and is ready to transition into Head Start or another prekindergarten program. Both Head Start and Early Head Start programs must follow extensive federal requirements and often are licensed by the state in which they operate. Programs must adhere to a number of standards that support the development of healthy parent–child attachments, encourage parental involvement, promote school readiness, and be culturally and linguistically appropriate (*www.acf.hhs.gov/ohs/about*). State-funded preschool programs provide high-quality preschool services to 4-year-olds from low- and moderate-income families. Care is offered to qualifying families at little to no cost, which allows more at-risk children access to quality early childhood experiences.

The myriad of options available require parents to make difficult, yet important, decisions regarding their children's care. Key issues that must be considered include the cost and quality of care, staff qualifications and training, program policies, hours of operation, as well as proximity to home or work and transportation. Parents must often engage in a complex analysis of the costs and benefits of a particular child care option before making the choice that is right for their family. Often, especially for families of low socioeconomic status, decisions are based on more practical concerns (e.g., affordability, transportation) rather than on the quality of the child care setting. In fact, cost, as well as other barriers, may limit access to high-quality nonparental care. In many states, the cost to parents for quality early care and education is nearly twice as expensive as a year of tuition at a 4-year public college (Giannarelli & Barsimantov, 2000), which sometimes requires parents to place their children in questionable environments that do not support healthy development and leave children vulnerable to negative developmental outcomes.

The dramatic rise in maternal employment has resulted in the need for a number of social policies to regulate the provision of early care and education services to young children across the country. In November 2014, President Barack Obama signed into law a quality initiative, the Child Care and Development Block Grant (CCDBG) Act of 2014. This law included several measures that required states to define health and safety requirements (e.g., standards regarding staff–child ratios and group size, criminal background checks of caregivers, ongoing training in first aid, sudden infant death syndrome [SIDS] prevention) for early care and education professionals, outline family-friendly eligibility policies (e.g., gradual phase-out of assistance for parents whose income has increased, eligibility redetermination after 12 months, continued benefits for 3 months after parental unemployment), and ensure that parents and the general public have transparent information about the child care choices available to them (e.g., electronic access to monitoring and inspection reports, websites that describe licensing policies and processes). Finally, and importantly, the CCDBG Act required states to engage in activities designed to increase the quality of care provided to young children (e.g., increase quality set-aside and dedicate funds to infant and toddler care, establish professional development and training requirements, develop Early Learning and Development Guidelines; Administration for Children and Families Office of Child Care, 2014). In response, states have rapidly built, evaluated, and changed their accountability systems for ensuring quality early care and education (e.g., Quality Rating and Improvement System (QRIS), professional development, licensing and standards) in order to be in compliance with the law.

As a result of these initiatives, policymakers have been afforded an opportunity to make a significant and lasting impact on young children's successful development by designing and implementing effective policies and programs that support healthy whole-child development and ensure that children are provided the foundation they need to succeed throughout their lives. Since nonparental care is likely to be a continuing part of most children's lives, it is important to determine the factors that may lead to negative effects and how early care and education environments can be designed to promote positive social–emotional development and infant and early childhood mental health.

The Benefits of Quality

For more than 50 years, state and federal governments have focused on improving early care and education programs to support children's readiness for school, with particular empha-

sis on supporting children from low socioeconomic status backgrounds. In 2015, The U.S. Department of Health and Human Services provided funding to early care and education programs, including Head Start and Family Services programs, and child care programs, to serve 2.5 million children at a cost of more than $15 billion dollars (Federal Safety Net, 2016). At the state level, by 2015, publicly funded prekindergarten programs in 42 states served approximately 1.4 million children nationwide at a cost of over $6.2 billion (Barnett et al., 2016). As significant investments continue to be made into these programs, the focus of research efforts should rest on not only the level of quality but also the impact of these initiatives on children's development.

While it has not been proven conclusively that child care is either advantageous or detrimental for young children when compared to parental care, research indicates that being cared for in high-quality early care and education environments is associated with a variety of positive outcomes in a number of domains, including cognitive, social, emotional, and language development (Lamb & Ahnert, 2006; National Institute of Child Health and Human Development [NICHD] Early Child Care Research Network, 2006; Peisner-Feinberg et al., 2001). The Abecedarian Project (Campbell, Pungello, Miller-Johnson, Burchinal, & Ramey, 2001), the HighScope Perry Preschool Program (Nores, Barnett, Belfield, & Schweinhart, 2005), and the Infant Health and Development Program (McCormick et al., 2006) evidenced sizable effects on language, academic, and social outcomes while the children were enrolled. The outcomes achieved were maintained, although in a somewhat diminished capacity, into early adulthood. An examination of additional research has yielded similar findings, with effect sizes ranging from very small to moderate, depending on the study (Burchinal, Kainz, & Cai, 2011; Pianta, Burchinal, Barnett, & Thornburg, 2009).

In one study, Caughy, DiPietro, and Strobino (1994) demonstrated that the reading and math achievement of children at ages 5 and 6 was influenced by two factors: age at entry into child care or years of experience in an early childhood program. However, these findings were not consistent when examining results of children from different socioeconomic backgrounds. In fact, children from more disadvantaged backgrounds, who had entered an early care and education program earlier and/or spent more years in out-of-home care, achieved higher reading scores when compared to children who spent fewer years in out-of-home care. Interestingly, for children from the highest socioeconomic backgrounds, negative effects were observed. Watamura, Phillips, Morrissey, McCartney, and Bub (2011) examined niche effects across low- and high-quality home and child care environments to determine the conditions under which young children are most at risk for early social–emotional problems. Results demonstrated that children who experienced both low-quality home and early care, and education environments were reported to have more challenging behavior and lower social–emotional competence, but not when compared to a group of children who experienced low-quality parenting and high-quality child care, suggesting that high-quality child care environments may serve as a protective factor for vulnerable children.

A meta-analysis of five early childhood studies revealed that children in lower quality programs had poorer outcomes than children in higher quality programs (Burchinal et al., 2011). However, effect sizes were modest, and the association between quality and child outcomes was only observed for children in high-quality environments and primarily with instructional support measures. Additional research has supported the notion that quality environments more strongly predict academic gains than does social–emotional development. Keys and colleagues (2013), in their study of preschool center quality and school readiness, found that the observed quality of preschool-age children's classrooms was modestly related to overall improvements in language and math skills. Moreover, increased language skills were realized for children of highly educated mothers (e.g., bachelor's degree or higher), and improved social skills were demonstrated for children who entered preschool with lower cognitive skills or had mothers with some college.

In additional to quality effects, it is necessary to briefly discuss the impact of time spent in early care and education programs on children's developmental outcomes. Studies suggest that the quantity of care is associated with behavior problems, even when researchers control for quality, especially when considering the development of social skills. As discussed earlier, the majority of children in the United States are placed in nonparental care, often by 3 months

of age, while both parents work (NICHD Early Child Care Research Network, 2003). Previous research has demonstrated that children who spent extensive amounts of time (i.e., 30 hours or more per week) in out-of-home care were rated by their teachers as having more problem behaviors, especially externalizing behavior, by age 4½ (NICHD Early Child Care Research Network, 2004). Although the majority of children do not exhibit behavior problems that rise to the level of clinical significance, aggressive behavior in the preschool years predicts later aggression (Campbell, Spieker, Burchinal, Poe, & the NICHD Early Child Care Research Network, 2006; Crick et al., 2006), and positive interactions predict more appropriate prosocial skills with peers (Blandon, Calkins, Grimm, Keane, & O'Brien, 2010), which sets children on a trajectory of success.

A more recent study suggests that while these findings are valid, the effect sizes are typically small but comparable to the effects of quality and last just as long (Huston, Bobbitt, & Bentley, 2015). This may be explained by factors such as the specificity of these findings to teacher, but not parent, reports (Dinnebeil et al., 2013); externalizing, but not internalizing behaviors; and children from minority backgrounds, single-parent households, lower socioeconomic backgrounds, and homes with lower maternal education (Huston et al., 2015). What is purported to explain the impact of time is the quality of interactions between teachers and children. When teachers provide sensitive and supportive caregiving, as well as developmentally appropriate behavior management techniques, the effect of time on child outcomes is reduced (Huston et al., 2015), which underlies the importance of the attachment relationship on children's healthy development.

Attachment and Child Care

Shonkoff and Phillips (2000) demonstrated that young children develop in the context of their caregiving relationships. Moreover, John Bowlby, in 1973, suggested that children form secure attachment relationships with their caregivers when there is stability and predictability in caregiving routines. This concept underlies the basis of our current understanding of the significance of child–caregiver relationships in healthy developmental outcomes. Attachment research has primarily focused on mother–child relationships, but less is known about how relationships form between children and subsequent caregivers, such as teachers. Research, however, does support the notion that close and secure relationships predict positive social–emotional outcomes in young children and, conversely, that interruptions in the caregiving relationship negatively affect children's development (Howes & Spieker, 2008), and children who do not have strong, secure, and ongoing attachment relationships are at risk for a variety of negative outcomes, including social and emotional difficulties, behavioral problems, and even learning delays (Dicker & Gordon, 2004). Yet when these attachment relationships are strong and secure, the caregiver is the most important factor in a child's ability to successfully navigate the demands of development, achieve positive outcomes, and recover from traumatic experiences (Zeanah & Zeanah, 2001).

There have been concerns that extensive and early (under age 12 months) experience in nonmaternal care may lead to insecure attachments between infants and their mothers. Before the NICHD Study of Early Child Care and Youth Development (NICHD Early Child Care Research Network, 1999), which examined children experiencing nonmaternal care, there was conflicting evidence about whether young children receiving substantial amounts of care from someone other than their mother experienced disruptions in attachment. However, these studies had several methodological limitations, including small sample sizes, lack of control for variables that could have influenced study findings (e.g., quality of child care), and use of a retrospective model, among others (Friedman & Boyle, 2008). The NICHD Study of Early Child Care and Youth Development found that maternal sensitivity was most predictive of infants' subsequent attachment to their primary caregiver (NICHD Early Child Care Research Network, 1999). Poor-quality early childhood environments contributed to insecure attachments in young children when their mothers were less sensitive. For infants with sensitive mothers, the length of time spent in care and the quality of care did not influence infants' subsequent attachment to the primary caregiver (NICHD Early Child Care Research Network, 1997).

For most children, the primary caregiving relationship is with their parents; however, the development of healthy and stable relationships between children and their caregiver(s) is the

foremost feature of quality child care (Shonkoff & Phillips, 2000). Children who are securely attached to their caregiver(s) in child care are more competent in their interactions with adults and peers as babies and toddlers through the second grade (Howes, 2000; Howes & Hamilton, 1993; Howes, Matheson, & Hamilton, 1994; Howes, Rodning, Galluzzo, & Myers, 1988), which sets the foundation for more positive developmental outcomes in the future.

Special Circumstances

For children facing risk factors at home, such as poverty or maternal depression, among others, high-quality child care may support the child's and family's recovery and healing both in terms of ameliorating negative outcomes and increasing protective factors. For example, infants with families living near or at the poverty line who attended high-quality child care had mothers who showed more positive interactions with them at 6 months than did infants with a similar socioeconomic status who attended low-quality care or were at home with their mothers (Caughy et al., 1994). Moreover, quality child care has been found to protect infants and children from the negative effects of living with a mother who has depression (Cohn, Campbell, & Ross, 1991; Cohn, Matias, Tronick, Connell, & Lyons-Ruth, 1986). Alternatively, infants and young children experiencing risk factors in their home environment who also receive low-quality child care are at increased risk for experiencing more insensitive mothering (Shonkoff & Phillips, 2000). This may further exacerbate their difficulty in establishing and/or maintaining positive relationships with their caregivers at home and in the early care and education environment.

Similarly, for children in foster care or children at risk for being removed from their biological parents, the primary attachment relationship is at risk. This may jeopardize the child's ability to form healthy attachment relationships and realize positive developmental outcomes. However, in the United States, it is estimated that a young child typically forms attachment relationships with between one and three or four individuals (Boris, Aoki, & Zeanah, 1999); therefore, a secure attachment relationship with a child care teacher for young children in early education settings may offer similar benefits to a secure attachment relationship with a parent (Shonkoff & Phillips, 2000) and could possibly support the child in recovering from traumatic events. In fact, children's adaptive social development is supported through secure, stable attachment relationships with their child care providers (e.g., Pianta & Nimetz, 1991; Sroufe, Fox, & Pancake, 1983).

Continuity of Care to Support Infant Mental Health and Attachment

Taking into consideration the number of children who are cared for in out-of-home placements while parents work and the significance of developing strong attachments to caregivers, it is important to examine how caregiving discontinuity in early care and education environments impact child outcomes. *Discontinuity* can be defined broadly as unnecessary disruptions or inconsistency in care that negatively impacts children's development of secure relationships with their teachers (Sandstrom & Huerta, 2013). Discontinuity primarily occurs in either of two ways: as children transition to new classrooms when they get older or reach certain developmental milestones, such as crawling or walking (Cryer, Hurwitz, & Wolery, 2001) or through daily disruptions as they move in and out of different rooms, so that child care centers can maintain legally required staff–child ratios (De Schipper, van IJzendoorn, & Tavecchio, 2004). This latter type of discontinuity most often occurs in the early morning or late afternoon, when fewer staff members and children are present (Whitebook, Howes, & Phillips, 1990). Discontinuity can also occur as a result of teacher turnover (Cassidy, Lower, Kintner-Duffy, Hegde, & Shim, 2011), which tends to be higher in low-quality early care and education environments. In all cases, however, a change in caregiver has implications for not only the relationship but also the caregivers' ability to meet the needs of the young children in their care. As a result, children in early care and education programs typically have a number of different caregivers throughout their first 3–5 years of life, which decreases the likelihood that they will form healthy attachments to caregivers to whom they can reliably turn to get their needs met (Raikes, 1993). More frequent changes in primary caregiver during the first 3 years of life have also been associated with negative child outcomes, including increased aggression (Cryer et al., 2001), higher levels of externalizing behaviors

(Pilarz & Hill, 2014), and withdrawing behaviors in the preschool years (Howes & Hamilton, 1993). Moreover, research has suggested that frequent teacher movement was negatively associated with perceived teacher–child closeness and children's reports of whether they liked being in the program (Le, Schaack, & Setodji, 2015). Children's rate of movement was positively associated with ratings of the child by peers and of peers by the child (Le et al., 2015), which is likely due to increased exposure to different groups of children.

The National Association for the Education of Young Children (NAEYC) encourages early care and education programs to establish policies that allow teachers to provide relationship-based developmentally appropriate care to children in their earliest years. Assigning one teacher as primary caregiver over a significant period of time (i.e., 2–3 years) allows teachers to engage in practices that are tailored to the individual needs of children and to develop trusting relationships with their families (Brazelton & Greenspan, 2000; Cryer et al., 2001). Research suggests that implementing continuity of care of this type yields positive results for both children and families through more sensitive caregiving practices, and for teachers in the form of increased knowledge and improved practices (Ackerman, 2008).

Despite the stated benefits of continuity of care, however, research on prevalence rates indicates it is rarely practiced in the United States. In a study of staffing patterns for infants and toddlers (Cryer et al., 2001), less than two-thirds of participating programs reported that children stayed with the same teacher as they moved up to the next class. The low incidence is likely attributed to practical concerns faced by early care and education programs, such as class size and available space, as well as developmental considerations and the complexities involved in caring for children of different ages. Qualitative research has demonstrated that strong leadership, positive beliefs, and high levels of commitment are necessary for successful implementation of continuity of care (Garrity, Longstreth, & Alwashmi, 2016). Perceived barriers, including time constraints and a lack of professional development opportunities, were found to be critical factors (Garrity et al., 2016) that must be addressed to assist early care and education professionals in creating settings in which children can thrive and develop positive relationships with others.

Challenges to Supporting Healthy Infant Mental Health in Child Care

Quality child care demands individualized care of infants and young children, which translates into low teacher–student ratios. This labor-intensive work results in high costs for families. Approximately 80% of child care costs go to teacher salaries, yet child care teachers remain some of the lowest paid workers (Whitebook & Sakai, 2003). To illustrate, for a child care teacher to place two children in a high-quality child care program in the United States, she would need to spend, on average, 81% of her income on child care costs. While there are subsidies available, parents are responsible for, on average, 60% of child care costs. With such low wages, 25 to 30% of early care and education teachers report high levels of stress and burnout, which contributes to higher levels of staff turnover and of child expulsion (Whitebook & Sakai, 2003). When teachers and/or children are changing programs, they must develop new relationships, and this can become a barrier to developing supportive attachment relationships.

Approximately 12% of young children between ages 2 and 5 have social, emotional, or mental health concerns that contribute to seriously challenging behaviors (Egger & Angold, 2006). Disruptive and challenging behaviors can contribute to teacher burnout and difficulty establishing positive relationships between teacher and child, and can result in the child's expulsion from the early childhood program. Preschool expulsion rates are 3.5 times higher than K–12 expulsion rates (Gilliam, 2005), with 39% of preschool teachers having expelled at least one child for challenging behaviors (Gilliam, 2006). Boys and children of color are expelled more often than girls and European American children (Greenburg & Ash, 2012). Being expelled from a child care setting impacts children's ability to maintain consistent relationships with caregivers and peers, and can lead to family stress. For example, preschool expulsion may impact the parents' ability to work, resulting in children sometimes being moved from place to place while an appropriate child care solution is found. However, teachers who had access to an infant and early childhood mental health consultant with specialized training in social–emotional development of young children reported reduced expulsion rates for all children, including children of color (Gilliam, 2005, 2007; Shivers, 2011).

Family Engagement

Engaging families in the early care and education environment is important for improved child outcomes. In their review of the research on family engagement, Henderson and Mapp (2002) found that children whose parents were more engaged demonstrated better social skills, improved behavior and adaptability, and attended more regularly. Similarly, Knopf and Swick (2008) noted that engaged families were more satisfied with the early care and education programs they had chosen, and their children demonstrated better academic outcomes and larger vocabularies. While early care and education programs are typically businesses, engaging parents and families is a key aspect of providing quality care. Douglass (2011) encourages the use of a relational bureaucratic approach, which is "associated with high-quality family partnership practices" (p. 1). This relationship-based business model for early care and education programs places emphasis on supporting and building relationships between and among center staff members, which should serve as a foundation for how they welcome and engage parents. This focus on relationships parallels the relationship focus of infant and early childhood mental health and is a promising approach for running an early care and education program. More conventional business models with hierarchical managerial structures may hamper an early care and education program's attempts at engaging families (Douglass, 2011). Therefore, as the child care industry continues to grow and professionalize, adoption of business models such as the relational bureaucratic model will be important.

Methods of engaging families that may be used in this type of child care program include developing a warm and welcoming environment for both staff and families (Knopf & Swick, 2008). Ensuring that staff members have a positive attitude toward families and value families as partners is key to successful family engagement (Baum & Swick, 2008). For environments to be welcoming to all families, early childhood programs must consider and be sensitive to cultural differences, including race, ethnicity, socioeconomic status, and ages of parents, among other factors (Arndt & McGuire-Schwartz, 2008; Knopf & Swick, 2008). This can be accomplished through a variety of mechanisms including: home visits, surveys and questionnaires, telephone conversations, emails, parent conferences, family communication journals, welcome meals, visits to the school before the child starts, and having a live person answer the telephone (Arndt & McGuire-Schwartz, 2008; Knopf & Swick, 2008). Just as infants and young children need to be cared for consistently and unconditionally, when the early childhood program's relationship with the family is approached in a similar way, positive relationships can develop and contribute to a positive experience in early care and education for the child, teacher, and family.

Infant and Early Childhood Mental Health Consultation as Primary Support for Young Children in Child Care

Infant and early childhood mental health consultation (IECMHC) is "an intervention that teams a mental health professional with early childhood professionals to improve the social, emotional, and behavioral health of children in child care and early education programs" (RAINE Group, 2014, p. 1). IECMHC seeks to support all children, teachers, and families involved in an early care and education setting and can combine child-, program-, and classroom-focused interventions. IECMHC has been found to support improvements in teacher child relationships (Conners-Burrow et al., 2013; Heller et al., 2012), reduce children's behavior problems, and increase children's social skills (Conners-Burrows et al., 2013; Gilliam, 2007, 2016; Gilliam, Maupin, & Reyes, 2016; Shivers, 2011), and prevent expulsion (Gilliam, 2005). Moreover, IECMHC supports teachers by decreasing levels of stress and burnout (Brennan, Bradley, Allen, & Perry, 2008; Conners-Burrows et al., 2013) and also contributes to parents' missing less work (Van Egeren et al., 2011) due to their children being expelled from preschool.

Our IECMHC model, Tulane Infant and Early Childhood Mental Health Consultation and Support Services (TIKES), is a combined model of IECMHC that provides both programmatic (i.e., a focus on improving the overall program) and child-centered consultation (i.e., a focus on the needs of a particular child). The three primary goals of TIKES are to promote healthy social–emotional development of young children as a component of healthy whole-child development; to increase teachers' skills and knowledge to effectively support social–emo-

tional development of young children; and to refer for treatment and/or design interventions for children exhibiting challenging behaviors, developmental concerns, or mental health concerns.

Social–emotional development may be defined as "children's ability to experience, regulate, and express emotions; form close and secure relationships; explore the environment and learn" (Parlakian, 2003, p. 2). Social–emotional skills in childhood, such as self-regulation, predict the adult health outcomes related to substance dependence, wealth, and criminal convictions (Moffitt et al., 2011). As children develop their social–emotional skills in the context of their caregiving relationships, including the ones formed with the child care caregivers, the Center on the Developing Child at Harvard University (2011) recommends using IECMHC to train and support early care and education teachers to use effective classroom management skills and to support their understanding of how to actively teach young children social–emotional skills. The TIKES program works with teachers to support their understanding and encourage children's developmentally appropriate social–emotional skills. We accomplish this through observation, modeling, and interactive trainings over a period of 6 months with weekly or every other week visits, depending on the size of the center. Our program evaluation has demonstrated that positive teacher–child interactions as measured by the Classroom Assessment Scoring System (CLASS; Pianta, La Paro, & Hamre, 2008) increased after 6 months of consultation and remained high 6 months after consultation had ended (Heller et al., 2012). In addition, teachers reported an increase in their sense of teaching self-efficacy and competence in supporting social–emotional development (Heller et al., 2011). These self-reported scores also remained elevated 6 months after the consultation had ended.

With the majority of U.S. children under the age of 5 spending a large portion of their day learning, playing, and developing in early care and education programs while their parents work, the attachment relationships these young children form within their child care settings contribute to their long-term health. While children's relationships with their primary caregivers remain most important, their attachment relationships with child care teachers and the social–emotional development that occurs during their time in out-of-home care is a crucial component of early development. Quality of child care contributes greatly to a child's early experience in the early learning environment. Early care and education sites can work toward supporting young children's healthy development by adopting family-friendly approaches and continuity of care that support healthy attachment, while using IECMHC to help meet the mental health needs of young children.

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