Big Feelings:
Parents and Caregivers Need More Help to Support Children Under 5

Children Now®

Focus Group Revelations & Recommendations

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Contents

Introduction

From birth through age 5, a child's brain develops more rapidly than any other point in its life. It is a uniquely critical stage where the foundation of their brain is formed, and can be weakened by experiencing stress or trauma.[1] This makes the role of parents and caregivers of children under 5, and their impact on development, immensely consequential.

Currently, these parents and caregivers are not receiving enough support from the State to provide kids the environments best for their behavioral health and wellness, as discovered in an investigation conducted by Children Now. Through a series of focus groups, parents and caregivers of diverse backgrounds discussed the behavioral health needs of their children under 5, and the myriad of issues — from interpersonal to systemic — that affected their child's healthy brain development. The most impactful revelations from those conversations are detailed throughout this brief.

While each child and family's experiences are unique, the collective findings reveal that to meet the State's goal of reducing adverse childhood experiences (ACEs) and toxic stress by half within one generation, as well as advancing the Governor's commitment to improving the mental health of our state's children and youth, California must do a better job of supporting the social emotional health of children ages 0 to 5. An effective solution requires a multi-layered, multi-systems public health approach to child, family, and community-wellbeing.

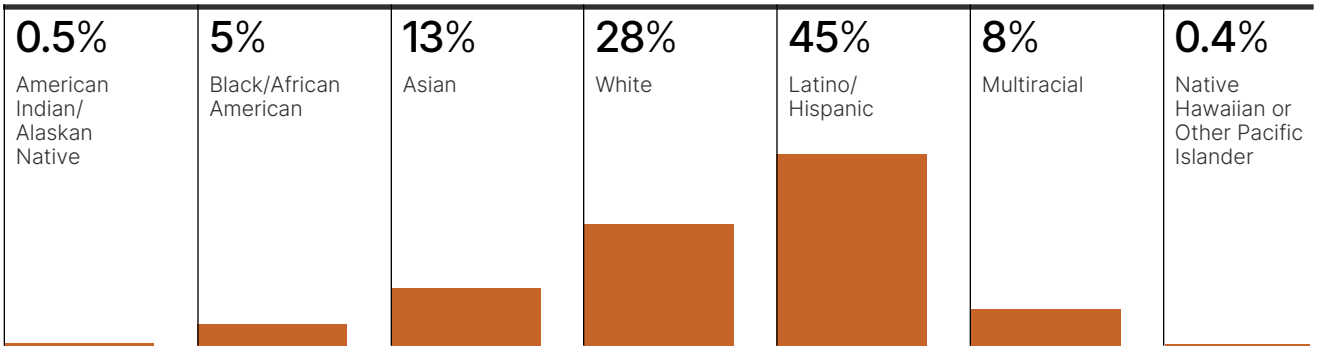
Across 8 focus groups, in three languages, 64 parents and caregivers have spoken up about their experiences and needs to care for the behavioral health of kids under 5. **To provide them the necessary support, we need to listen.**

What Parents Say	Policy Recommendation
Use of the outdoors to foster resilience	Make safe and clean outside spaces accessible for all families.
Decoding baby talk	Aim at reducing burdens in families' lives, by bolstering paid family leave, developing the childcare workforce, and funding child development programs.
Access to intervention services is uneven and costly	Continue addressing the physician shortage, investing funds into developmental screenings, holding health plans accountable, and integrating systems.
Navigating wait times proves unwieldy	Continue expanding the behavioral health workforce, especially for providers who offer care to families with young children.
Communication and trust between providers and parents fall short	Invest in data-sharing infrastructure, promote integration with the child care system, diversify the physician workforce, bolster physician bias trainings, and leverage community partnerships.
Fathers often overlooked	Invest in fatherhood educational campaigns that offer father-specific resources.
Fear of being judged impacts confidence in decision making	Invest in culturally-competent, stigma-reducing campaigns aimed at both providers and families.
Parents feel the emotional toll	Continue investing in "whole-family," models of care.
Safety net key in supporting families	Prioritize ensuring that all eligible families are enrolled in programs they need and continue to stay enrolled.
Parents find support in community-based organizations	Invest sustained funding into community-based organizations.

Demographic Information

There are over 2.6 million children under the age of 5 in California.[2] Most recent estimates show that 36% of these young children live in families that make less than 200% of the federal poverty guideline — $53,000 for a family of four.[3, 4] Furthermore, California's young children are incredibly diverse (see below). This demographic context can help explain the social conditions that impact young children's behavioral health and shape targeted intervention.

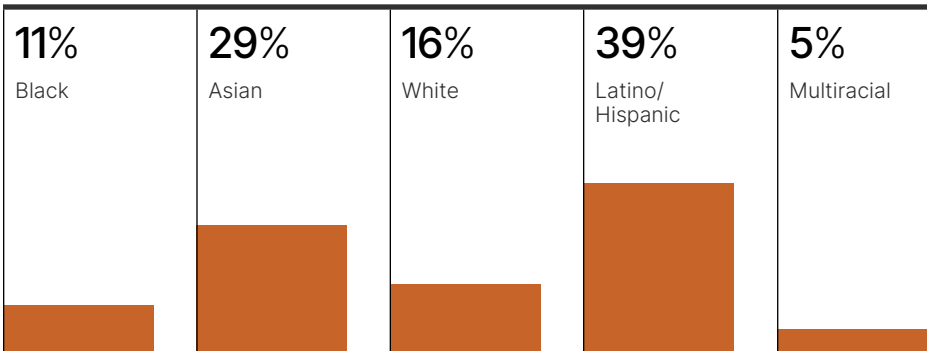
Race/ethnicity breakdown of children under the age of 5 in California, 2023



Demographic Information of Participants

Children Now actively sought a diverse set of focus group participants. It was important to give under-represented groups a platform to share their experiences in seeking behavioral and emotional care for their young child, along with their desires for policy solutions. Regarding race and ethnicity, the recruiting efforts drew a minority-majority sample, with over 80% of participants identifying as a person of color. While most participants identified as female, 28% identified as male and 2% identified as non-binary or pangender. Over 30% of participants spoke a language other than English — largely Spanish and Hmong. The overwhelming majority of participants resided in densely-populated counties, namely Los Angeles County, Fresno County and Orange County.

Race/ethnicity of participants



Total of 62 participants; two participants didn't respond.

Theme: Use of the outdoors to foster resilience

When searching for ways to support their young child's behavioral health and well-being, parents across every focus group spoke to the importance of outside spaces. They identified the outdoors as one of their primary tools to promote their young children's emotional regulation, aid their children in learning about the world around them, and simply bond as child and caregiver. Public outside spaces also reduced social isolation by serving as spaces of community gathering and outreach with other parents. For many, being outside was one of the first steps to building resiliency.

"If (my son is) really upset about something and if it's a weekend or something, then we'll be like, 'Do you want to go outside and just take a walk?' And usually, he'll say, 'Yes.' Then, he'll usually forget about what he was frustrated with and just get excited about doing something else or going outside."

Mother to a 2-year-old

"(A local organization provides the) opportunity to meet at a local park and just bring the resources to the moms so the moms don't have to go out and be seeking in all these different directions. The kids are entertained at a park, and then the moms can be having those discussions and conversations in an outside setting versus another sterile building that moms have to go into."

Mother to a 2-year-old

"We go outside and go for a walk. And it really helped because we got to engage like, 'Do you see the dog? Woof, woof, woof. And the bird? Tweet, tweet, tweet.' That really helped develop language in that aspect because she was excited to go outside. Now she says, 'I want to go for a walk.' So, it really helped me."

Foster mother to a 2-year-old

What the research says

Outdoor play is a staple in children's routines, both inside and outside of school. Feeling the sun, breathing fresh air, and moving around freely releases serotonin (the body's "happy hormone") and increases the production of Vitamin D (a key nutrient in both physical and cognitive health). Access to green space is also associated with lower stress and lower risk of neurodevelopmental problems like inattentiveness,[5] and also provided one of the best settings for bonding between young children and trusted adults.[6]

Policy Recommendation

According to most recent estimates, 21% of all California residents live further than half a mile from a park.[7] In addition, park access is inequitable throughout the State, varying greatly based on geographic location and local demographics.[8] This inequity will likely worsen as climate change advances. Once temperatures rise and air quality worsens, outside play will be increasingly more difficult, especially for California families who already lack steady access to public outdoor spaces.

Recently, the State began providing direct park funding to low-income communities across California.[9] However, ensuring equitable access to safe public spaces should remain a policy priority. Thorough community engagement is critical in park and playground development, to ensure that the space is safe, clean, and meets the needs and preferences of residents. The State should also prioritize building accessible sidewalks, cleaning up streets and making more green spaces as part of public schools that are accessible to the entire surrounding community.

Theme: Decoding baby talk

While infants and children under 5 have behavioral health needs, many are not able to articulate them. While some parents shared experiences of their children demonstrating more widely understood behavior to signal their emotions (ex: crying while sad or smiling while happy), many spoke of instances where the behavior was more subtle or less predictable (ex: crying in moments where they're expected to be happy). These parents learned and relied on their child's unique babbles and cues to indicate their behavioral health needs that doctors and family members frequently missed.

"It's weird because it goes in ebbs and flows where everything will be really good, and then everything isn't. And it's been really actually hard pinpointing what causes the transition where there's a huge shift in behavior, because there haven't been any big life events. That doesn't mean that he doesn't interpret things that way and maybe I'm just not seeing it."

Mother to a 3-year-old

"We learned her language. We learned what she was saying when other people couldn't."

Father to a 2-year-old

"I'm really learning...how perceptive they are and how able they are to give you the details once you learn to understand their body language and how they convey these things."

Grandfather to a 16-month-old

What the research says

In the first several months of life, babies primarily communicate with body language —crying, thrashing their arms and legs, and smiling. As babies grow into infants, they begin to babble by stringing together sounds they hear in their environment. As children become toddlers, they increasingly rely on both body language and words to communicate, but even then, their limited vocabulary of an average of up to 10,000 words for a 5-year-old[10] can make understanding their emotions difficult.

When parents respond to their child's attempts to communicate, the young child brain and their ability to communicate strengthens, making them more likely to communicate again.[11] This creates "serve-and-return" interactions between parent and child.[12] Parents and caregivers that are in tune with their child's development can become efficient young-child decoders.[13] This can be especially critical when parents and caregivers need to communicate their child's needs on their behalf to a doctor or family member.

Policy Recommendation

Research suggests that parents and caregivers are less likely to notice or participate in these vital "serve-and-return" interactions in times of significant burden and stress.[14] Thus, policy solutions should be aimed at reducing burdens in families' lives, so that parents can better respond to their child's development milestones. Bolstering the State paid family leave (PFL) policy will enable parents to take time to bond with their child, reduce disparities for groups (like low-income workers) who historically take leave at lower rates,[15] and make California more competitive with other states that lead the nation on PFL policies.[16]

The State should continue to fund child development and enrichment programs (like home visiting) so that all adults in a child's life can learn how to implement best practices in their daily lives. The State should also continue to develop the child care workforce, so that all children are able to access flexible, high quality care and have more opportunities to develop the social interaction skills.

Theme: Access to intervention services is uneven and costly

For many parents and caregivers, seeking intervention services for their child was self-initiated (such as noticing they were struggling with emotional regulation or a developmental milestone). However, when they did seek services themselves, many were unsuccessful. This was frequently because of a shortage of quality, affordable resources in the local area.

"San Benito County is where I live. We don't have a lot of services, but I work in Santa Clara County, which has a ton of services. So (the care your child receives is dependent on) where you live and what's available to you."

Father to a 2-year-old and a 1-year-old

"I've only tried to get support or services one time. I went through (my insurance), and I did the whole intake (for a program) and they're like, 'We really don't provide services for a 3-year-old unless they have an Autism diagnosis.'"

Mother to a 3-year-old

"My son was having some behavior issues at school. First, I talked to the school. The teacher didn't want to make a referral to get services through the school because she knows that I rely on him going to school there for childcare. And even though it's not their first step, ultimately, if you continue to have challenges and it was documented on their record, they would move to reduce his hours, which then would put me in a hardship because I don't have childcare. I still haven't been able to get services."

Mother to a 6-year-old and 3-year-old

What the research says

Fourteen percent of children 3-5 years old nationwide are reported to have a mental, emotional, developmental or behavioral concern.[17] However, some research suggests that in California, as little as 3% of infants and toddlers receive intervention services.[18]

As the parents/caregivers in the focus group noted and the data supports, it can be incredibly difficult to find resources to address these concerns. Current estimates report that 45% of Californians live in counties with insufficient access to a primary care provider, who are often the first resource parents seek out for their young child's behavioral or emotional concerns.[19] This, coupled with California's low rates of developmental screenings and well-child visits by Medi-Cal providers,[20] creates dangerous conditions that allow for children who need help to fall the cracks.

Policy Recommendation

In previous years, the State worked to increase funding for the screenings children need to ensure they are reaching their age-appropriate developmental milestones. For example, in 2019, California approved the use of tobacco tax funds to reimburse Medi-Cal providers for developmental and trauma screenings. However, monetary investments are only one part of increasing screening rates for young children.

The State should continue addressing the physician shortage that makes it hard for families to get seen in the first place, holding health plans accountable for failing to meet quality measures, and ensuring that the systems are properly integrated, so that families can receive appropriate referrals for services.[21]

Theme: Navigating wait times proves unwieldy

Once an appropriate and affordable service was located, many parents reached out to the support services they needed across multiple systems and reported experiencing significant procedural issues. Some parents also noticed parallels between the systemic issues within the early childhood behavioral health system and other congruent systems, like early childhood education. When addressing the needs of young children, parents felt that many systems were not appropriately reactive to parents' concerns.

> "Going through the referral process and then private insurance just seems impossible. Waiting for somebody to call back and knowing you need to call this person. Now you have to call that person. For parents that might have two jobs or might not be familiar with the process, that can be very overwhelming and (parents) can give up just because of how hectic the process can be just to find services for the child."
>
> Mother to a 2-year-old and 10-month-old

> "I always really believed that those first 3, 4, 5, 6 years (of a child's life) are so critical. These wait times to get into programs and to therapy seem to gobble up a lot of that time. If it takes you six months to get into a program, that's a good portion of (those early years)."
>
> Mother to a 4-year-old and 3-year-old

> "(We need) to have a stable child development workforce...In general, it feels like we're really operating on shoestrings right now. We heard that for decades, but post-pandemic, it's really, really, really hard."
>
> Parent and early childhood education provider

What the research says

In a survey of over a dozen pediatric specialty medical groups across California, it was found that the Developmental/Behavioral Pediatric specialty had some of the longest median patient wait times compared to all pediatric specialties, at 106 days.[22] Furthermore, many parents reported that "healthcare system/provider issues and barriers" were the main reason that they delayed or didn't access care for their child altogether.[23]

However, receiving needed care as a child under age 5 is critical. The infant and early childhood brain and body are developing rapidly during these years, and problems that go unidentified or unaddressed can significantly impact a child's health outcomes later in life.

Policy Recommendation

California recently invested more funding in the behavioral health workforce.[24] These investments are expected to reduce wait times for families by increasing the number of providers that are available. California should continue those investments, with a special focus on expanding the workforce needed for adults who care for very young kids. The State should also ensure that these systems of support offer "whole-child" or "whole-family" resources, so that families receive opportunities for more complete care, that they may not have received otherwise.

Theme: Communication and trust between providers and parents fall short

If and when parents were able to secure treatment for their young child, many reported their experiences to be inadequate. The behavioral health needs of children under 5 can be hard to identify. Parents and caregivers felt that the chasm between what they knew about their children and what early childhood professionals observed about their children made it more difficult to receive needed services. This was especially prevalent for children who were experiencing significant behavioral health disruptions that did not fit more rigid diagnostic criteria. In addition, gaps in cultural alignment and experiences with medical racism made some families of color resistant to a diagnosis altogether.

"You really just have to speak up...and read...do your own research...so you're prepared when you show up and you talk to a professional. For example, we've been trying to get her started on occupational therapy and we keep getting told, 'No, she's fine. She doesn't really need it.' But, we are seeing that she would really benefit from it."

Mother to a 3-year-old

"(My son) has been at therapy a couple times, and I noticed too when they graduated him or when they think he's good enough to be graduated, we regressed backwards. And then we reached out to another therapist, we were fine for a while and then, now that he's graduated again, he's regressing. My only frustration was they weren't listening to what I was trying to tell them or how I felt."

Parent and early childhood education provider

"My family and my husband believe in the traditional Hmong belief. When my son hadn't started talking, we went to the doctor and the doctor referred us to a specialist. But when we talked to my father-in-law, he said that maybe there's something wrong with his spirit (which was why) he's not talking yet. We asked a shaman to come do...this ceremony and then now the child talks now. So, it could be that we seek Western services and now he's speaking, or it could be that we did this as a shaman's ceremony and his soul is now attached to his body and now he's speaking again."

Mother to a 5-year-old and 2-year-old

What the research says

The physician-patient relationship is an integral part of quality care. A physician-patient relationship based on trust, compassion, shared information, and communication can improve diagnosis and treatment outcomes.[25] However, 66% of surveyed parents in California said that their child's doctor did not ask them if they had concerns about their child's learning, development or behavior in the past year.[26]

Many parents and caregivers spoke to the information gap present in medical settings — parents know that physicians have education and training but feel like the treatment process is not explained to them. Families of color raise these same concerns, in addition to concerns of a lack of cultural competence and medical racism.[27] For example, one report found that over 25% of Black Californians said they avoided medical care out of concern they would be treated unfairly or with disrespect.[28] When medical providers respect the racial and cultural context of their patients' experiences —as one California hospital did when they merged traditional Hmong practices with Western medicine[29]—the physician-patient relationship can be a powerful healing tool.

Policy Recommendation

One goal of a robust healthcare system is making the process more transparent for parents so that they can better advocate for the needs of their child. To address this, the State should have more robust investment in data-sharing infrastructure, continue integrating vital systems like the child care system and explore practices that can help physicians be more trustworthy.

By allowing parents better access doctors' notes and treatment plans, making child care providers accessible to speak to the emotional or behavioral issues a child presents to their doctor and promoting the use of family navigators to help families communicate with physicians, State policy can improve the relationship between physicians and parents/caregviers.

Theme: Fathers often overlooked

In many families, fathers and male caregivers felt disregarded by early childhood professionals and health care providers. Fathers spoke to an unstated assumption that the mother was the sole parent involved in the care of their child. Many fathers and male caregivers articulated a societal bias that impacted not only professionals' interactions with them, but also their own understanding of their role in their child's health. Thus, pertinent information was siloed, leaving them feeling unequipped to make informed choices.

"I've had the experience where I share 50/50 custody with the mother of my children, and I've been there since day one for my youngest child. And I just felt that I was always excluded from everything; all the conversations were always geared towards mom. I want more inclusion (of) the fathers...We're present, and we're involved. We want to learn too."

Father to a 2-year-old

"Some dads are still following some of their parents' models of like, 'I'm going to take care of things. I'm going to work hard. I'm not going to be as engaged in different things.' So, I think normalizing (paternal involvement is important). It took me a while too to be like, 'It's okay to ask for help, it's okay to ask for services, it's okay to share with other guys what I'm going through.'"

Father to a 5-year-old and 2-year-old

What the research says

Traditionally, mothers and female caregivers have been more involved in the direct health care of their children than fathers and male caregivers.[30] However, national research shows that the role of fatherhood has significantly changed over the decades and as many stated in the focus groups, men want to be more involved.

Fathers and male caregivers are significantly more involved in parenting today than they have in previous generations.[31] This can lead to positive health outcomes. For example, studies have shown that when fathers were involved, mothers were more likely to receive prenatal care and children were less likely to experience poor behavioral health down the line.[32] Despite this, many fathers and male caregivers report feeling maligned by health care professionals who saw the father-child relationship as supplemental to the mother-child relationship.[33] Therefore, fathers felt less knowledgeable about the health care needs of their child and less confident about how to play an active role.

Policy Recommendation

State departments should participate in fatherhood educational campaigns, by targeting information and resources to new dads. For example, fathers are increasingly taking paid family leave to bond with their newborns, but still at rates lower than mothers.

Any fatherhood educational campaign should spread awareness of paid family leave, and any resources available to support themselves and their partners, so that fathers can play an active role in creating a safe, healthy environment for their family from the beginning of their child's life.

Theme: Fear of being judged impacts confidence in decision making

For many parents and caregivers, their children's behavioral health concerns felt like a direct negative reflection on their parenting. Many described behavioral health disruptions as something "being wrong with their child," caused by a parenting "failure." They also spoke to a fear of judgment from their extended families, early childhood professionals, or the community writ large.

> "I just remember it being a very dark, sad time where I felt like all of that was happening to my daughter was my fault...because I didn't know everything earlier. Maybe I wasn't taking the doctor's directions correctly enough when I was pregnant."
>
> Mother to a 2-year-old

> "It's like, 'No, my child is fine. I don't want that to be on my child's record." (There is this fear) of being judged maybe by other family members, friends, or the community, or thinking that this is going to have a negative effect on the child's reputation."
>
> Parent and early childhood education provider

What the research says

In general, many parents feel anxious about raising a child. Reliable, non-stigmatizing information on best parenting practices is often hard to find. While some local groups, like First 5 Orange County, launched campaigns to destigmatize seeking help for the behavioral and emotional health of young children,[34] these efforts are not statewide.

Perceived judgment from early childhood behavioral health professionals can significantly impact parents' decision making. Families who felt judged when receiving care for their child were less likely to be involved in their child's treatment, were less likely to adhere to a treatment plan, and were also less likely to seek care again.[35]

It is important that parents and caregivers are supported by doctors, early childhood professionals, and loved ones, as stigmatizing rhetoric can prevent them from getting the help their child needs.

Policy Recommendation

The State should continue to invest in educational, stigma-reducing campaigns. For example, the State could continue promoting and normalizing developmental screenings to parents by using positive, pro-family, and strengths-oriented language. Stigma can also vary with cultural norms and understanding, so campaigns need to be culturally competent. These campaigns should also target doctors and early childhood professionals, who may use language that alienates parents and caregivers from the care process.

Theme: Parents feel the emotional toll

Parents care deeply about the behavioral health of their young children and pursue various avenues to get help. For many, the lack of sleep when caring for an infant, the stressors of work-life balance and financial instability all contribute to feelings of depression and anxiety. These every-day challenges were compounded during the pandemic, leaving many parents unable to see their usual supportive networks (e.g., family and friends). This created an emotional toll that weighed heavily on many parents.

"She was dealing with a lot of postpartum depression at the time. Breastfeeding issues were another concern, like the baby wasn't getting enough milk daily. So, it was a lot of stress during that time. Around that time also, I had a panic attack at work and went to the ER. I thought I was having a heart attack. I've never had a panic attack before. So, it was a big wakeup call for all of us."

Father of a 4-year-old

"I broke out in hives from stress. I was diagnosed with severe sleep apnea and fatigue. I thought it was just the normal thing of being a father. I realized my body (was) physically shutting down."

Father of a 5-year-old and 2-year-old

What the research says

Across California, nearly 15% of women experienced prenatal depression and 13% experienced postnatal depression.[36] While less well-researched, it is estimated that 10% of fathers and male caregivers also experience depression, though typically a few months after the baby is born.[37] Both maternal and paternal depression are defined by sustained, intense sadness and despair that can prevent daily functioning.

Depression—along with other anxiety and mood disorders that can arise during the birth of a child—have significant impacts on parent and child. It can negatively impact a parent's ability to bond with their child and increases the risk of future behavioral health problems in children down the line.[38, 39]

Policy Recommendation

Traditionally, California's mental health investments have been limited to individual treatment. However, recent investments in doula services, promorotas and dyadic therapy highlight the importance of whole-child approaches. Going forward, the state should actively support new parents and caregivers by providing emotional and mental health support before it is requested. Programs like home-visiting, can be key when pro-actively identifying and referring parents and caregivers who may be at-risk of suffering from anxiety and depression to services.

Theme:
Safety net key in supporting families

Many parents sought help in supporting their child's behavioral health outside of traditional clinical pathways, such as using state programs like CalFresh as a resource. These programs sometimes directly offered help with parenting, but other times addressed a more basic need, like access to food.

"I started going back to college this year, just this spring. They actually offer the diaper program, and they have other resources for single parents. I don't have to pay to go to school, and they help also with extra vouchers for food…and for the books. Between school, (CalFresh), and CalWORKs, I've gotten a lot of help, so, I've been really grateful for that."

Mother to a 3-year-old

"Well, with my first (child) I didn't know anything, as a first-time mom. But, you know what helped me a lot? (CalFresh). The in-person classes helped me a lot. That's why during the pandemic, when my baby was born, I really missed them because it was like starting everything over again. I loved the in-person classes they taught at CalFresh…because I learned plenty…about food, about nursing."

Mother to a 3-year-old

What the research says

Many Californians are supported by social welfare programs. For example, children under 18 comprise around 22% of the State's entire population, but around 37% of all CalFresh recipients.[40] CalFresh can help families achieve the food security that a growing child needs, but also allows families to free up extra money that can go towards other needed resources, like child care.[41] These safety net programs also dramatically reduce child poverty.[42] Thanks to increased government assistance due to the pandemic, 1.7 million children across the State were lifted out of poverty.[43]

Programs like CalFresh, CalWORKs and Medi-Cal help to interrupt the self-enforcing cycle between unmet basic needs and negative health outcomes. When families are better able to meet their needs, they can focus on reducing stress in the family environment and supporting their young child's healthy development.

Policy Recommendation

Families' access to state programs can vary with changes in state and federal budgets, changes in eligibility requirements, and/or system procedures that are difficult for families to navigate. These issues can make it hard for families with young children to keep their coverage, creating a "churn" issue where children cyclically un-enrolled and re-enrolled.

In 2025, the State will implement a continuous coverage policy for children under 5 with Medi-Cal.[43] Until then, it is imperative that the State acts to protect these children from losing the health coverage they need. California should also consider shortening program applications, building infrastructure for cross-program enrollment and pursuing other avenues to increase take-up rates of CalFresh, CalWORKS, Medi-Cal and other state programs, so that every eligible family is enrolled.

Theme: Parents find support in community-based organizations

A significant number of parents talked about the positive role non-profits and community-based organizations (CBOs) played in the well-being of their family. These organizations offered practical resources, like direct access to food or parenting classes, and even helped families navigate complex procedural systems. Other community spaces, like libraries and churches, were also a source of support. These communal and familial networks were sometimes preferable to more standard (and Western) sources of care, especially for some communities of color.

"I actually reached out to an organization. They stepped in with the county because they said, 'The county really should be advocating and helping you.' And once I kind of lit the fire under (the county's) seat, my daycare is almost all paid for now."

Grandmother to a 17-month-old

"My daughter, she is a single mom, divorced, and I have to help her. That's my number one reason why I decide after (retiring from) 30 years of preschool, to open my daycare because I say, 'If I have to wake up 5:00, 6:00 in the morning for just my grandson, I wake up for others too.'"

Grandmother to a 5-year-old

"We do have a faith community with our church and at least that was a very big, emotional support for us...There was times where there was really good emotional support from our faith community, our church, people who really love her. (Some of the other) resources that I thought would be really helpful, I felt a lot of times failed us."

Mother to a 4-year-old and 3-year-old

What the research says

In community-based programs, care and support are delivered in spaces children and their families frequent and allow families to play an active role in their delivery. Community-based services are distinct from clinical services and are an essential part of the behavioral health system for young children.

Examples of services at the community level include facilitated playgroups, parenting support classes, and others. These programs are uniquely positioned to help families overcome barriers to behavioral health care access, and they can connect families and educators with more intensive health, mental health, or early intervention services as needed. Community-based programs are also most likely to reach families from historically marginalized communities, including immigrant families, low-income families, and families of color.

Policy Recommendation

California needs to expand its investments into community-based organizations. The recent investments made through the Children and Youth Behavioral Health Initiative for very young children have been helpful for local CBOs. However, that funding is one-time in nature, reducing the ability for these organizations to have a lasting impact in their communities. By focusing state dollars on community-based interventions, California can ensure diversity in programming that supports our unique population.

Conclusion

Despite varied geographies, languages and identities, parents and caregivers shared similar experiences when seeking care for the behavioral and emotional needs of their young children. They spoke not only of how systems made it difficult to support their families, but also how they fought for their children's right to healthy and happy lives. Many parents and caregivers were easily able to identify what worked and what didn't work in their experiences.

California has the resources to invest heavily in families. With the words and experiences of these parents and caregivers as a guide, the State should prioritize its budgets and legislation to better serve children under 5.

Children Now is on a mission to build power for kids.

The organization conducts non-partisan research, policy development, and advocacy reflecting a whole-child approach to improving the lives of kids, especially kids of color and kids living in poverty, from prenatal through age 26.

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Endnotes

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