January 19, 2024

The Honorable Khari Garvin
Director
Office of Head Start (OHS)
330 C Street, S.W. 4th Floor
Washington, DC 20201

Re: RIN 0970-AD01. Supporting the Head Start Workforce and Consistent Quality Programming

Dear Director Garvin:

Thank you for the opportunity to comment on the proposed rule RIN 0970-AD01 that proposes changes to the Head Start Program, specifically the proposed changes regarding mental health services within 45 CFR Part 1302, Subparts A, D, H, and I.

Mental Health America (MHA) – founded in 1909 – is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the mental health of all. With nearly 200 affiliate organizations in 41 states, our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention services, early identification, integrated care, behavioral health services, and supports.

We commend OHS for its focus on mental health within these proposed rules, particularly the emphasis on integrating mental health across settings, the focus on prevention, and the understanding that the mental health of adults is a critical component contributing to the mental health of the young children they care for. MHA writes to support these changes and urge OHS to finalize these proposals, including the proposal to include a minimum of one mental health consultation per month. Without this clear minimum, Head Start will not achieve the integration and early impact on mental health and wellbeing that OHS is seeking to promote and that national data on children's mental health indicates is desperately needed.

Subpart A – Suspensions and Expulsions
Head Start already has the laudable policy of prohibiting expulsions and limiting suspensions. As noted in the NPRM, preschool expulsions and suspensions can have long-term negative effects on child outcomes, and children of color—particularly African American boys—are disproportionately affected. Also as noted in the NPRM, challenging behaviors that are associated with suspensions are a crucial opportunity to implement mental health consultation rather than mete out punishment.

We support all the proposed changes to 1302.17 and are particularly supportive of the change to paragraph (a)(2) that would require the recommendations of the mental health consultant to be implemented before suspension is considered. We also strongly support the proposed addition to paragraph (a)(3) that adds the "multidisciplinary team responsible for mental health" to the listed participants who must decide potential steps before suspension is considered.

Subpart D – Health Program Services
We support the many proposed changes within multiple sections of Subpart D and appreciate the concerted focus in elevating mental health to the forefront of the overall health services component of Head Start. We applaud OHS for recognizing that early and frequent conversations about mental health

can have a significant impact on eliminating barriers to care and increasing the possibility that a future mental health condition can be prevented.

We appreciate the explicit emphasis on mental health in the renaming of the Subpart from "Health Program Services" to "Health and Mental Health Program Services". This makes clear that the Program has an intentional and dedicated focus on mental health.

We broadly support the numerous proposed changes to the Subpart—particularly those in 1302.45—and are pleased to see the clarification that mental health promotion and prevention of mental health conditions is a key aim of the Program. As we did for Subpart A, MHA fully supports the multiple proposed additions of the "multidisciplinary team responsible for mental health", which reflects that OHS recognizes the importance of a team-based approach involving professionals specializing in different areas to achieving wellness and optimal mental health.

We do have a comment for the proposed change to 1302.45(a)(3) that would replace "schedule of sufficient and consistent frequency" with "no less than once a month" regarding how often mental health consultation services must be provided. No less than once a month is the bare-minimum target for the frequency of mental health consultation services, and we would prefer the bi-weekly frequency recommended by SAMHSA's Center of Excellence in Infant and Early Childhood Mental Health Consultation.

At the very least, MHA urges the OHS to maintain the no less than once a month minimum and not to remove this requirement. OHS should work with SAMHSA to provide guidance on efficient ways to provide consultation across a Head Start population in a manner that best promotes prevention, early identification, and follow up for those with more significant mental health needs. Without a minimum number of consultations, this requirement is meaningless and will not have the intended effect of integrating early behavioral health care into Head Start where it will have the most impact on children and families. There is strong evidence (see page 5) that prevention and early intervention efforts focused on very young populations can have a significant positive effect on later mental health outcomes. This research also found that "multimodal preventing programs combining preschool intervention and family support have been associated to the most enduring beneficial effects on a number of social outcomes, including significant better overall academic performances and lower delinquency and antisocial behavior rates." This is exactly what the Head Start Program should be striving for, and this will be much more difficult to achieve without a minimum number of consultations in place.

Subpart H—Services to Enrolled Pregnant Women and People

We broadly support the proposed changes to 1302.81, particularly the expanded scope of mental health conditions beyond just depression to "perinatal depression, anxiety, grief or loss, birth trauma, and substance use". As the NPRM notes, it is now widely understood that there are a multitude of possible mental health outcomes, including depression, that may occur or worsen during the perinatal period. Broadening the focus within 1302.81 is a critical and necessary improvement.

Subpart I—Human Resources Management

We support the proposed change to 1302.91(e)(8)(ii) regarding qualifications for mental health consultants. The new language adds those who are "under the supervision of a licensed" mental health professional as eligible participants for the mental health consultant role thereby increasing the pool of potential candidates. As noted in the NPRM, there is a behavioral health workforce shortage in many

areas of the country. Given that professionals who are not yet licensed but are under the supervision of a licensed mental health professional are permitted to provide direct mental health service in many settings, it is certainly appropriate for such professionals to serve as mental health consultants in the Head Start Program. While this expansion of eligible candidates is not a panacea for the current workforce challenges, it will increase the probability that the mental health consultant position is staffed.

We also strongly support the proposed new 1302.93(e) that reads "A program should cultivate a program-wide culture of wellness that empowers staff as professionals and supports staff to effectively accomplish their job responsibilities in a high-quality manner". Fostering workplace wellness should be a beacon for any employer or program. But it is especially important in a program such as Head Start. If staff are suffering from extreme stress, workplace toxicity, and burnout it is essentially impossible that the children and families they serve will achieve optimal outcomes. In fact, a lack of staff wellness will almost certainly filter down to children and families and lead to poorer outcomes that could have deleterious long-term effects. MHA's workplace research (2023 Mind the Workplace survey results) indicates that workers who feel psychologically safe overwhelmingly report that work-related stress does not negatively affect their mental health. Conversely, workers in unhealthy environments report higher rates of distress leading to increased mental health concerns.

In support of this new paragraph 1302.93(e), OHS should provide guidance and technical assistance on how programs can accomplish a culture of wellness. MHA's Workplace Resource Center has numerous resources for both employers and employees that OHS could rely upon to develop and implement this guidance and technical assistance.

Thank you for providing MHA with the opportunity to comment. For questions or further information, please contact us at mgiliberti@mhanational.org or tclement@mhanational.org.

Sincerely,

Mary Giliberti

Chief Public Policy Officer
Mental Health America
mgiliberti@mhanational.org

Tim Clement

Tim Clement

Vice President of Federal Government Affairs
Mental Health America
tclement@mhanational.org