

# Promoting the Mental Health and Healthy Development of New York's Infants, Toddlers and Preschoolers:

*Advancing the Agenda, Sustaining the Gains  
A Call to Action*

June 2011



## **Preface**

**Promoting the Mental Health and Healthy Development of New York’s Infants, Toddlers and Preschoolers: Advancing the Agenda, Sustaining the Gains: A Call to Action**, was prepared by the New York City Early Childhood Mental Health Strategic Work Group. The Work Group is an advisory group to the New York City Department of Health and Mental Hygiene. Members include experts from the fields of early intervention, health, mental health, early care and education, child welfare and the judicial and academic systems. The group was convened to develop an action plan for New York City and New York State to address the mental health needs of infants, toddlers and preschoolers and their families.

## **New York City Early Childhood Mental Health Strategic Work Group**

### ***Evelyn J. Blanck, LCSW -- Work Group Chair***

Associate Executive Director, New York Center for Child Development  
Co-President, New York Zero to Three Network

### ***Robert Abramovitz, M.D.***

Distinguished Lecturer  
Hunter College School of Social Work  
Co-Director National Center for Social Work Trauma Education and Workforce Development

### ***Andrea D. Bennett, LMSW***

Director, Early Childhood Mental Health  
University Settlement

### ***Rahil D. Briggs, Psy.D.***

Director, Healthy Steps at Montefiore  
Clinical Instructor of Pediatrics, Albert Einstein College of Medicine

### ***Susan Chinitz, Psy.D.***

Director, Early Childhood Center  
Associate Professor of Clinical Pediatrics  
Albert Einstein College of Medicine

### ***Barbara Greenstein, LCSW, Ph.D.***

Deputy Executive Director  
Child Center of New York

### ***Bruce Grellong, Ph.D.***

Chief Psychologist  
Director, Center for Child Development and Learning  
Jewish Board of Family and Children’s Services

***Dorothy Henderson, LCSW***

Associate Director, Infant-Parent Study Center  
Director, Judicial Consultation Project  
Institute for Infants, Children and Families, Jewish Board of Family and Children's Services

***Rochelle Macer, LCSW-R, ACSW***

Former Director of Mental Health Policy and Planning  
Office of Child and Family Health  
New York City Administration for Children's Services

***Heather R. Mermel, MPH***

Director of City and Federal Policy and Advocacy  
The Coalition of Behavioral Health Agencies, Inc.

***Rebecca Shahmoon-Shanok, LCSW, Ph.D.***

Director, Institute for Infants, Children and Families  
Jewish Board of Family and Children's Services

***Joan Siegel***

Senior Policy Associate for Health and Mental Health  
Citizens' Committee for Children of New York, Inc.

***Erika Tullberg***

Administrative Director of the ACS-NYU Children's Trauma Institute  
NYU Langone Medical Center

We are grateful for the contributions of members of the Work Group to the preparation of this White Paper. In addition to Work Group members, the following experts made significant contributions to White Paper information and analyses.

***Gilbert M. Foley, Ed. D.***

Associate Professor of School-Clinical Child Psychology, Ferkauf Graduate School of Psychology, Yeshiva University  
Consulting Clinical Director, The Early Childhood Mental Health Consultation and Treatment Program, New York Center for Child Development

***Michael Gordon***

Executive Director  
New York Center for Child Development

***Judah Koller, Psy.D. Candidate***

Ferkauf Graduate School of Psychology, Yeshiva University, Psychology Intern  
The Early Childhood Mental Health Consultation and Treatment Program  
New York Center for Child Development

***Dina Lieser, MD, FAAP***

Attending Pediatrician New York Hospital Queens  
Director, Docs for Tots

***Daniel Schechter, M.D.***

Chief of Pediatric Consult-Liaison and Parent-Infant Research,  
University Hospitals of Geneva and the University of Geneva Department of Psychiatry  
Adjunct Assistant Professor of Psychiatry, Division of Developmental Neuroscience and Behavior,  
Department of Psychiatry, Columbia University College of Physicians & Surgeons

***Sheila Smith, Ph.D.***

Director, Early Childhood  
National Center for Children in Poverty

***Erica Willheim, Ph.D.***

Clinical Director, Family PEACE Program at New York-Presbyterian Hospital

***Serena Wieder, Ph.D.***

Co-Founder ICDL and DIR Institute, Developmental and IMH Consultant

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We extend our appreciation to **Susan Blank**, who skillfully edited this report, and for her many suggestions on how best to convey its ideas and analysis.

We believe the 2005 White Paper played an important and constructive role in alerting policy makers to the need for government to play a more active role in promoting early childhood mental health. We write this White Paper to update the findings made then, to point to continued unmet mental health needs for young children in New York State, and to strongly urge policy makers to consider a series of recommended changes in governmental policy in order to support and promote the critical mental health needs of young children.

Respectfully submitted,

NEW YORK CITY EARLY CHILDHOOD MENTAL HEALTH STRATEGIC WORK GROUP

***Evelyn J. Blanck, Work Group Chair***

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## **Executive Summary**

A growing body of research makes it clear that mental health problems in children younger than age 5 are both more prevalent than commonly thought and very often go untreated. Between 9.5 and 14.2 percent of U.S. children ages 0-5 experience social-emotional problems that negatively affect their functioning, development and school readiness (Brauner & Stephens, 2006). A 2004 study found that less than 1 percent of young children in the U.S. with emotional-behavioral problems are identified (Conroy, 2004). At the same time, interventions to promote the social-emotional health of very young children can help to ensure they enter school ready to learn and to take important first steps toward productive adulthoods.

Updating a 2005 report that had a positive impact on the way New York City and State address mental health issues for infants, toddlers and preschoolers, this White Paper offers ideas and solutions about how public systems serving families in New York City and State can do more to minimize the degree to which mental health problems regularly affect the lives of young children. This report recommends the development of a more comprehensive and coordinated service system to address the mental health needs of children ages 0 to 5. The system would be supported by a public health framework that calls for a continuum of care that encompasses: actions that promote mental health for the entire population of infants, toddlers and preschoolers; actions that prevent problems in a narrower segment of the population at high risk; and actions that intervene with young children already suffering from symptoms of mental health disorders.

This report has been produced by the New York City Early Childhood Mental Health Strategic Work Group. Members of the group are experts from the fields of early intervention, mental health, preschool special education, child care, child welfare, and the judicial and academic systems. Under the auspices of the Federation for Mental Health, an advisory committee to the New York City Department of Health and Mental Hygiene, the Work Group produced the 2005 White Paper to serve as a blueprint for action to improve mental health services for young children in New York. The original 2005 White Paper and this updated 2011 version of the report are the only public policy documents that focus exclusively on the issue of how to address the mental health needs of children younger than 5 throughout all New York City and State systems that serve children and families.

## **Research-Based Principles**

This report proceeds from the following principles, reflecting an extensive body of current research, about social-emotional health and disorders in young children:

- Development in young children does not result exclusively from either hereditary constraints or environmental influences but from an interaction between nature and nurture. The Harvard University National Scientific Council on the Developing Child describes an “explosion of research in neurobiology that clarifies the extent to which the interaction between genetics and early experience literally shapes brain architecture.” ( National Scientific Council on the Developing Child, 2007).
- Relationships are key to young children’s development and they matter as early as infancy. For this reason, therapy to address mental health disorders in young children should always be relationship-based -- meaning that children are served within the context of their caregiving relationships, joint

child-parent therapy sessions are held, and as needed, parents and caregivers receive professional attention along with their children.

- Risk factors for young children’s development have cumulative power to undermine good outcomes. Numerous studies of children show that the accumulation of exposure to multiple adversities over time intensifies their harm and can overwhelm existing protective factors.
- Development in one domain affects development in others. Especially for very young children, the processes of physical, cognitive and social-emotional development are closely related to one another. For this reason, it is important to fully take account of the social-emotional component of conditions such as developmental disabilities and others that are sometimes viewed solely as impairments in cognitive and/or physical functioning.
- There is a strong research-based case for economic investments in early intervention. Several highly regarded research studies point to very positive benefit-cost ratios that accrue to society when tax dollars are devoted to high-quality interventions for young children at risk for poor outcome (Heckman, 2007). While the programs covered by these studies have not been concerned exclusively with mental health problems, their outcomes suggest that high-quality early interventions to promote young children’s mental health are a financially sound long-term investment for New York City and State.

## ***Highlights of Recommended Changes for Public Systems Serving Children and Families***

Development of the more comprehensive mental health system for young children that this White Paper calls for depends on changing many of the current policies and practices of the individual public systems that serve children and families – notably, systems focused on developmental disabilities, mental health, health care, early childhood care and education, and child welfare. This report presents system-by-system recommendations for changes designed to advance progress by viewing mental health services as not the responsibility of any one child-serving system but of all. This shift in perspective calls for a comprehensive and coordinated system that would address the whole child and all domains of development based on the individual needs of the child and caregiver, regardless of which doorway they enter to get access to services. The system would be marked by more pooling of skills and knowledge across disciplines and more involvement of parents and caregivers in interventions. Members of the Work Group and their advisors recognize that creating a fully integrated system is a goal that will take many years of concerted effort, but they are convinced that the actions recommended in the report would move services very far in that direction.

Both in this Summary and in the body of this report, recommendations and data are most heavily focused on New York City. However, especially in light of the strong interest the earlier 2005 White Paper evoked in a number of state policymakers and practitioners and also because this report covers key state-funded systems that affect children, the recommendations in this report are meant to inform discussions of how to strengthen mental health services for young children not only in New York City but throughout the state.

Readers are referred to the full report for capsule descriptions of the relevant services of the systems that are covered and for fuller and more inclusive presentations of recommended steps that each system could take to help build a comprehensive early childhood mental health system. What follows are highlights of some key recommendations:

- Early childhood mental health specialists should be co-located in primary health care practices to ensure that social-emotional domains of development are identified and addressed.
- Practices in several systems should be changed to improve the chances of early identification of social-emotional problems among infants and toddlers. Notably:
  - Protocols for health screenings of infants and toddlers should include social-emotional domains.
  - Pediatric providers, residents, and medical students should be trained to recognize signs of social-emotional problems in the infants and toddlers who are patients.
  - The New York State Early Intervention (EI) system should use screening tools and procedures that specifically probe for social-emotional delays.
  - Screening and assessment of very young children in the child welfare system should include the use of standardized screening and assessment measures with established psychometric strengths.
  - Physicians caring for newborns and their mothers should routinely screen for maternal trauma and depression.
- The Committee on Preschool Special Education (CPSE), which provides services for children between the ages of 3 and 5 who exhibit a significant delay or disability, should review its policy of recommending interventions for preschoolers only if their disabilities interfere with their ability to learn. CPSE should consider broadening its criteria to give more weight to children who have social-emotional problems that do not immediately affect their learning but that ultimately could do so.
- The EI system which is authorized to provide services to infants and toddlers with disabilities and their families on the basis of norm referenced assessment of development in all five domains, should act on that authority with equal rigor by granting services to children who meet eligibility criteria in the social emotional domain only .
- Efforts should be made to encourage early childhood programs to use nationally recognized mental health prevention and treatment models and curricula.
- New York City and State early childhood programs and systems should consider undertaking new outreach strategies that help ensure that children who are homeless, involved in the child welfare system, or have other life circumstances that place them at exceptionally high risk for mental health problems, are enrolled in high-quality early childhood programs that promote healthy social-emotional development.
- Working in collaboration with other institutions, the New York State Office of Mental Health (SOMH) should develop vigorous campaigns to educate the public about mental health and about how to assure emotional wellness in very young children. These campaigns should also aim to reduce the stigma of seeking help to address young children's mental health problems.

- Children’s mental health clinics licensed by SOMH should partner with primary care providers to better coordinate physical and mental health care, and to ensure young children’s access to specialty mental health care services when they are needed.
- Health care insurers should be required to reimburse for accepted diagnoses for mental health problems for children under 5 years old.
- The Administration for Children’s Services (ACS), the agency responsible for New York City child welfare services, should promote and endorse evidence-based parenting programs and parenting services to improve the ability of birth parents to provide nurturing care. Whenever possible, information offered in parenting classes should be tailored to the concerns of individual parents and children.
- Mental health members of each ACS Clinical Consultation Team should be required to have knowledge of principles of early childhood development and early childhood mental health and to have expertise in the assessment of and intervention with children birth to age 5.
- The standard used to decide if parents with children in foster care will be granted more contact with their children should shift from indications of whether parents have complied with service plans or completed courses. Instead the standard should center on observed positive changes in parenting, especially improvement in the areas that originally generated ACS concern.
- ACS training and supervision should place more emphasis on the nature and importance of child-caregiver attachment relationships and the implications of trauma for young children.
- Preventive and foster care agencies should be required to establish linkage agreements with organizations that provide infant and early childhood mental health services and supports.
- ACS and the EI system should work collaboratively to ensure that particular attention is paid to the social-emotional and trauma-related needs of young children with substantiated cases of abuse and neglect who are given EI screenings and services.

This White Paper also stresses that progress in creating a more integrated and effective system of mental health services for young children depends on developing a more integrated system of training that focuses on social-emotional development of infants and toddlers. This system should provide information and guidance to professionals and others who work with young children in various systems that are outside of but relevant to the field of mental health. At the same time, the system should meet the needs of professionals working within the mental health field whose expertise does not focus on young children. While this report does not present a detailed blueprint for a new or expanded training system for these two groups, suggestions are offered on guiding principles that could be used to design a more expansive and cohesive training system in New York, on key topics that training should cover, and on modes of delivering the training.

## I. Introduction

“Early childhood mental health is the capacity of the child from birth to age five to experience, regulate and express emotions; form close and secure interpersonal relationships; explore the environment and learn.”

This definition of early childhood mental health, formulated by Zero to Three, a leading national organization focused on early childhood issues, describes a start to life that most adults would agree is what they want for children they care about -- and indeed for the next generation (Zero to Three, 2004). But even before entering school, many young children face social and emotional problems that keep them from realizing the capacities that Zero to Three views as the essential components of mental health – problems that by the early years of schooling are strong predictors of difficulties with later academic and social functioning (Shonkoff and Phillips, 2000). Mental health problems in children below age 5 are both more prevalent than commonly thought and very often go untreated. According to a policy brief from the National Center for Children in Poverty:

- Between 9.5 and 14.2 percent of U.S. children ages 0-5 experience social-emotional problems that negatively affect their functioning, development and school-readiness (Brauner & Stephens, 2006).
- A 2004 study found that less than 1 percent of young children in the U.S. with emotional-behavioral problems are identified (Conroy, 2004). Another study reports that nearly two to three times more preschool-age children in the U.S. exhibit symptoms of trauma-related impairment than are diagnosed (Scheeringa et al., NCCP).

This White Paper, which is grounded in current scientific research about mental health problems in children ages 0-5, aims to make the social-emotional development of these children a more visible and central policy concern for public systems serving families in New York City and State. Updating a 2005 White Paper that had a positive impact on the way New York City and State address mental health issues for infants, toddlers, and preschoolers, this report offers ideas and solutions about how public systems serving New York families can do more to minimize the degree to which mental health problems regularly affect the lives of young children. This report's recommendations and data are most heavily focused on New York City. However, especially in light of the strong interest the earlier 2005 White Paper evoked in a number of state policymakers and practitioners and also because this report



covers key state-funded systems that affect children, recommendations in this report are meant to inform discussions of how to strengthen mental health services for children not only in New York City but throughout the state.

This report grows out of a conviction about the critical need to support early intervention. Especially in light of what the Harvard University National Scientific Council on the Developing Child describes as “the explosion of research in neurobiology that clarifies the extent to which the interaction between genetics and early experience literally shapes brain architecture,” the case for taking early steps to support children’s healthy development has never been stronger. Efforts to alleviate the mental health problems of infants, toddlers, and preschoolers not only have direct value for children and families; they are a wise investment for society. As the Harvard Council points out, “creating the right conditions for early childhood development is likely to be more effective and less costly than addressing problems at a later age” (National Scientific Council on the Developing Child, 2007).

New York City’s and State’s wide variety of public systems serve children and families in a variety of settings, including health and mental health settings, the child welfare system, service programs for children with developmental disabilities, and early childhood programs. These systems all have the capacity -- and in some cases, the statutory responsibility -- to intervene to promote mental health in young children. As will be discussed in more detail throughout this report, New York’s child- and family-serving systems have the opportunity to move to the next level of cooperation and coordination to ensure that sensitive and thoughtful mental health interventions are available to children and families regardless of which system doorway they enter.

## ***Mental Health Problems in Young Children: What Do They Look Like?***

The following very brief descriptions of how mental health problems manifest themselves in infants, toddlers, and preschoolers are based on case material. Naturally, these profiles cannot be read as a complete or exhaustive description of mental health difficulties of young children. But they are intended to give readers a sense of the many kinds of situations and the many kinds of distress – with symptoms and conditions ranging from mild to severe – that are covered by the general description of “mental health problems in young children.”

### ***Mild Conditions and Symptoms***

**These problems tend to be adjustment disorders and exaggerated responses to situational changes in the context of a stable relationship between the child and parents or other primary caregivers:**

#### ***Infant:***

A 7-month-old baby becomes inconsolable when the mother tries to leave her with a babysitter to look for a job. The mother is at a loss about how to handle the situation.

#### ***Toddler:***

A 20-month-old girl, who had successfully slept through the night before the birth of her baby brother, now insists on having her mother stay with her in her bed while she falls asleep. The mother became frightened when the child threw a doll at the baby and nearly hit him in the eye.

**Preschooler:**

After his dog ran away, a 3-year-old is having severe nightmares. The child's preschool teacher tells his parents that the child is very inattentive in the classroom and often has trouble sharing toys with other children.

## **Moderate Conditions and Symptoms**

***These problems tend to cluster around anxiety, mood, behavioral, and communication disturbances:***

**Infant:**

A premature 6-month-old infant who was fed through a tube has difficulty transitioning to solids. The baby's caregiver has begun trying to force the baby to eat, leading to daily battles and increased spitting up. The mother is unsure about what should be done, but the caregiver tells her that if the baby is not compelled to eat, he will grow up to be willful and manipulative.

**Toddler:**

After a 2-year-old boy's father is severely injured in a car accident, his mother becomes distraught and preoccupied. The child shows intensified fear of being separated from his mother, has nightmares, and is extremely frightened of monsters. Although this toddler had been embarked on toilet training, his progress is now at a standstill.

**Preschooler:**

A 4-year-old girl with a lisp who lives in a family with increasing marital tension will speak only in a whisper to her teacher -- and to her parents when she is in public with them. Her mother complains that she has been very bossy and rude at home.

## **Severe Conditions and Symptoms**

***These problems often manifest themselves as anxiety, mood, communication, psychotic, and pervasive developmental disturbances. Often not only the child, but one or more primary caregivers, shows symptoms of being disturbed:***

**Infant:**

This baby was brought to a hospital emergency room with altered mental status following an unexplained skull fracture and was found at his eight-week medical examination to be only a few ounces above his birth weight. His worried mother, who has a history of psychiatric hospitalization, says that an evil spirit has entered the baby's body.

**Toddler:**

A 2-year-old girl has such severe separation anxiety that her mother cannot use the bathroom in privacy. The mother reports that this child has uncontrollable tantrums involving pulling out her hair and banging her head so hard against the floor that she has knots on her scalp. The child sometimes approaches strangers on the subway and holds their hands. The mother, who grew up in foster care, has a history of having been reported to the child welfare agency.

**Preschooler:**

A 4-year-old boy is thrown out of nursery school for breaking a little girl's nose with a baseball bat after having cursed at her. While he was in school, he was sometimes so tired that he fell asleep at his table or appeared to be in a daze. His teachers reported that the mother sometimes wore dark glasses and that her arm had recently been in a cast.

The kind of problems that have just been profiled – even those characterized as “mild” – spell distress and often suffering for children and their families. In every case, if these problems are left to fester, there are risks that they will worsen, making it less and less likely that the children who are afflicted will be able to stay on pathways to healthy development and learning. To make a major difference in outcomes for the kind of young children and their families who have just been profiled, they need access to a comprehensive early childhood mental health system focused on mental health promotion and prevention, and emphasizing early intervention and treatment.

**More on The White Paper: Origins, Accomplishments, and Next Steps**

The genesis of the original 2005 White Paper was a series of meetings, first convened in 2003, of a group of experts from agencies, academic institutions, and teaching hospitals that serve children birth through age 5. This group, known as the New York City Early Childhood Mental Health Strategic Work Group, came together out of a concern that the field of public health gave too low a profile to early childhood mental health issues. However, the purview of the group's discussions quickly broadened beyond public health to encompass other fields that serve children and families.

Under the auspices of the Federation for Mental Health, an advisory committee to the New York City Department of Health and Mental Hygiene, the Work Group produced the 2005 White Paper to serve as a blueprint for action. To date, this report is the only one of its kind to focus on the question of how to address the mental health needs of young children across all of New York City's and State's child- and- family service systems.

The response to the original White Paper was extremely positive. In meetings held with members of the Early Childhood Work Group even before the report was finished and over the years following its release, numerous city and state officials and other leaders have been eager to engage in dialogue about how the city and state can do more to promote mental health in young children. Since 2005, New York agencies have taken several important steps toward ensuring that mental health services for children ages 0 to 5 are part of the mainstream child- and-family service system:

- Under the umbrella of its Children Under 5 Mental Health Initiative, the New York City Council invested in mental health services for young children by funding eight innovative programs in different communities around the city.
- Both the New York State Office of Mental Health and the New York City Department of Health and Mental Hygiene have clarified that Article 31 mental health clinics, the mental health clinics that are licensed and regulated by the New York State Office of Mental Health, can request to amend their licenses to include services for very young children if they are not already authorized.
- The city and state have developed new mental health programs that expand the eligibility criteria for mental health services by allowing the provision of services to children under 5.

- Soon after the original White Paper was released, the New York City Administration for Children's Services, the city agency responsible for child welfare services, sponsored a conference on early childhood mental health for its line staff that recognized the prevalence of mental health needs in the child welfare system. These gains were reinforced by two important changes in laws that govern mental health and early childhood services.
- The 2006 state Children's Mental Health Act called on the state Office of Mental Health to produce a groundbreaking plan for a "comprehensive, coordinated children's mental health system", whose mandate included the need to address services for children ages 0 to 5. The Children's Health Plan was jointly signed and submitted to the Governor's office by nine Commissioners of New York State child-serving agencies.<sup>1</sup>
- The federal Head Start Reauthorization Act of 2007 mandated that states create early childhood advisory councils. The New York State ECAC, appointed by the Governor in 2009 and consisting of key leaders in fields affecting young children, is working to build a comprehensive early childhood system in New York State.

All of these changes have created an environment with unprecedented possibilities for developing a system of mental health services that works to prevent and address mental health problems of the city's children before they enter school. But despite the progress to date, the work is by no means finished. Not surprisingly one major problem is resources, relatively few public dollars are targeted to mental health services for New York's youngest children. An equally serious problem concerns the deployment of the resources that are available because they are not coordinated enough to maximize their impact. This fragmentation of the relevant service systems stems from each system having its own separate mandate, its own definition of what ages are to be served and how, and its own structure for delivering services. This new edition of the White Paper, which contains information on resources, groups and research findings that have emerged in the over five years since the original report was published, aims to help child- and-family-service systems move to the next level of cooperation and coordination.

This report's analysis uses an underlying public health framework familiar to many readers. It starts with a vision of a continuum of care for the population of interest – in this case, children under 5 and their families. Putting that continuum in place calls for routinely pursuing three kinds of actions: 1) promotion of mental health for the entire population; 2) prevention of problems in a narrower segment of the population at high risk; and 3) intervention services for those already suffering from symptoms of mental health disorders.

## ***A Roadmap to the Rest of This Report***

The balance of this report contains four sections: 1) a synthesis of key research information about social-emotional development and mental health difficulties of young children ages 0 to 5; 2) a discussion of the individual New York City and State systems that serve children and families and that have resources that can protect the mental health of young children, including recommendations of actions that should be taken by each of the systems; 3) a discussion of an issue that spans

<sup>1</sup>The nine state agencies are: Commission on the Quality of Care, Council on Children and Families, Department of Health, Department of Probation and Correction Alternatives, Education Department, Office of Alcoholism and Substance Abuse Services, Office of Children and Family Services, Office of Mental Health, and Office of People with Developmental Disabilities (formerly Office of Mental Retardation and Developmental Disabilities).

all systems– how to strengthen the mental-health-related training of professionals and other practitioners in institutions that provide key services to children and families; and 4) a call to action to encourage the city and state to take important next steps to fortify the social-emotional well-being of New York’s youngest children.

## ***II. A Scientific Overview of Mental Health Issues for Young Children***

### ***Nature and Nurture Are Intertwined.***

The familiar debate over whether nature or nurture has done the most to influence human development no longer persists. In its highly respected policy report, *Neurons to Neighborhoods*, the National Research Council/Institute of Medicine observes that although controversies about “hereditary constraints vs. environmental influences” – for example controversies on the efficacy of parenting versus early education – remain part of public discourse, these debates pose a false dichotomy: at the threshold of a new era in understandings about the biological bases for human growth, it is “time to re-conceptualize nature and nurture in a way that emphasizes their inseparability and complementarity, not their distinctiveness: it is not nature versus nurture, rather nature through nurture.” (pp. 39-41).

A good starting point for understanding what the Institute means by nature through nurture is to consider brain development in young children: According to leading researchers, the quality of a young child’s early experiences largely determines the formation and pruning of the brain’s synapses, a complex process that enables the young child to acquire information and make sense of the world in which he or she lives (Nelson & Bosquet, 2000; Shonkoff & Phillips, 2000).

Assuming that the child’s biology, relationships, and environment all conspire to give that child positive experiences, healthy development proceeds. But recent literature also confirms the harmful effects of early adverse experience at the neurological level.

Chronic or severe stress subjects a young child’s developing nervous system to toxic effects that subsequently affect a range of brain structures and functions (McEwen, 2003). The experience of fear activates a variety of physiological responses, including increased production of the stress hormone known as cortisol. Ongoing or severe exposure to traumatic stressors results in increased cortisol production, and excess cortisol negatively effects areas and structures of the brain that are essential to memory function (Carrion, Weems, & Reiss, 2007; Sapolsky, 2000), the capacity to integrate cognitive and emotional information, and the overall formation of synaptic connections (Berrebi et al, 1988). In addition, children with a history of maltreatment and post-traumatic stress disorder (PTSD) demonstrate a reduction in the size of brain structures responsible for integration of the right and left hemispheres of the brain (DeBellis et al., 2002). And recent studies have documented that children exposed to marital violence and maltreatment show increased activation of physiologic indicators of stress (Saltzman, Holden, & Holahan, 2005). In connection with these findings, it is important to note that the children who are exposed to violence are most likely to be very young. Children ages 0-3 have the highest prevalence of violence exposure (15.7/1000), followed by children ages 4-7 (13.3/1000) (NCANDS, 2004).

The research findings just cited support the construct of nature through nurture: the development of children’s brains can be influenced by their life experiences.

## ***Relationships are Key and They Matter as Early as Infancy***

For infants, the biology of stress exposure is not the only important influence on how the baby develops -- the relationship between the infant and the caregiver is also crucial (Hofer, 1984).

According to the National Scientific Council on the Developing Child, Harvard University:

“Healthy development depends on the quality and reliability of a young child’s relationships with the important people in his or her life, both within and outside the family. The development of the brain’s architecture depends on the establishment of these relationships” (Shonkoff, 2004).

Because relationships matter so much, there is broad consensus among child development experts that therapy to address young children’s mental health needs should be relational therapy – meaning that children are served within the context of their caregiving relationships, joint child-parent therapy sessions are held, and as needed, parents and caregivers receive professional attention along with their children.

One longstanding line of research that highlights the importance of the caregiver-young child relationship concerns the concept of attachment -- the primary reciprocal emotional relationship between the child and parents (Leiberman & Van Horn, 2008). In the right circumstances, the biological propensity for attachment provides an opportunity for an infant to form a close, positive emotional relationship with an adult, allowing infants and toddlers to develop security, confidence, and trust with their caregivers (Shonkoff & Phillips, 2000).

This relationship helps the young child explore his or her environment with confidence and manage stress (Ainsworth, 1967; Emde, 1980; Emde & Easterbrooks, 1985; Gunnar, 2000; Gunnar et al., 1996). However, insecure attachment to the primary caregiver in infancy can lead to poor emotional control, limited social skills, and a decreased capacity for play in school-age children (Zeanah, Mammen, & Lieberman, 1993). It should be noted that attachment is a two-way process- as is the genesis of any relational disturbance (Brazelton & Cramer, 1990). Just as parents influence infants, infants can have profound effects on their caregivers (Lewis & Rosenblum, 1974). For example, a difficult temperament in a baby can complicate the formation of a secure infant-parent attachment. In fact, any symptom profile is likely the result of complex multiple factors interfacing over time in linear and non-linear relationships (Galatzer-Levy, 2004; Sameroff & Chandler, 1975). Research on trauma also points to the key role that caregivers play in children’s emotional development. As defined clinically,



childhood trauma consists of children's direct experience or witnessing of an event or events that either involve or that feel like they involve actual or threatened death or serious injury to the child and/or others, or threat to the psychological or physical integrity of the child and/or others (DC: 0-3R, 2005).

Research indicates that the caregiver plays an important role in shaping the behavioral effects of trauma for young children (Scheeringa & Zeanah, 2001). During the first five years of life, as children are developing the brain structures which will eventually allow for self-regulation when exposed to stress or fear, caregivers serve as the regulators for arousal and attention. Disturbances in the self-regulation of caregivers when exposed to stress may severely impair the quality of regulatory functioning they can provide for their very young children (Schechter et al., 2005). At the same time, a soothing and sensitive caregiver who knows how to set limits on problematic behavioral symptoms with loving kindness that fosters a sense of safety can be an important source of help to a traumatized young child (Lieberman & Van Horn, 2004).

Research findings on maternal depression offer another instructive example of the way in which early experiences with caregivers can shape the emotional and cognitive development of very young children. Infants as young as 3 months of age are able to detect their mothers' depression (Cohn & Tronick, 1983), which typically is characterized by a lack of responsiveness, passivity or intrusiveness, withdrawal, avoidance, and low positive affect (Reck, et al., 2004). Research over the past 25 years has concluded that interactions of depressed mothers and infants compromise infants' social, emotional, and cognitive functioning as well as the parent-child attachment relationship (Goodman & Gotlieb, 1999; Tronick & Weinberg, 1997; Weinberg & Tronick, 1998). Problems have been found to persist into the school age years leading to difficulties in school performance, conflict with others, poor regulation of affect, and increased rates of psychiatric problems including a child's own depression (Rutter, 1990; Gelfand & Teti, 1990).

Maternal depression is far from a rare occurrence. A recent national survey (The Early Childhood Longitudinal Study) found that 14 percent of mothers of very young children exhibited clinical levels of depressive symptoms. (Depression was also found to be prevalent among fathers – 10 percent).

However, there are many interventions designed to ameliorate the adverse effects of mothers' depression on children. For example, studies have found that mother-infant psychotherapy and home-based interventions that focus on the mother-child relationship can head off these effects for young children (Nylen, et al. 2006).

## ***Risk Factors Have Cumulative Power to Undermine Good Outcomes***

Numerous studies of children show that the accumulation of exposure to multiple adversities over time intensifies their harm and can overwhelm existing protective factors. The direct relationship between the number of adverse events that children experience and the number of psychiatric problems they suffer demonstrates the cumulative effect of exposure to multiple risk factors (Harris, Putnam, Fairbank, 2006).

One study that probed the relationship between negative experiences and outcomes was the Adverse Childhood Experiences Study. Counting the number and types of adverse early childhood experiences (ACEs) using a 0-to-6 scoring system, this study examined the cumulative effects of

multiple ACEs on mental as well as physical health. The analysis provided compelling evidence of the deleterious impact of these experiences. Mounting numbers of adverse experiences occurring before the age of 18 years increased the risk of developmental delays and correlated positively with a range of lifelong physical and mental-health problems. Compared with subjects who had no ACEs, those who had four or more of these experiences were at a significantly greater risk for a broad range of serious health problems (for example, heart disease and stroke).

Another analysis indicated that children exposed to four or more cumulative risk factors had four times the number of psychiatric diagnoses compared to children with one risk factor. Depression rates were more than doubled, and suicide rates showed an eightfold to tenfold increase (Putnam, Perry, Putnam, & Harris, unpublished data, 2008).

## ***Development in One Domain Affects Development in Others***

It is common – and often very useful – to conceptualize the way children mature in terms of different kinds of development, with the domains most often categorized as physical, cognitive, and social-emotional. At the same time, it is important to recognize that there is no bright line that separates one of these domains from another. While there may be some reason to examine these domains separately for adults, in whom it is possible to trace somewhat differentiated areas of development that function autonomously, there is now broad agreement in the medical and mental health communities that it is far less valid to do this for infants and young children because for these age groups the domains of development are inextricably connected to one another.

For example, the unfolding of cognition depends heavily on the formation of a secure attachment between a child and caregiver. In the words of one child development expert, “Humans learn for love before they acquire a love of learning” (Ekstein, 1969). The emotionally secure base provided by the caregiver whom the toddler loves liberates the toddler to leave the caregiver’s lap without excessive anxiety and to turn toward the larger world to explore, master, and develop a zest for learning. Similarly, motor development fuels the loving relationship between infant and caregiver. For example, the infant’s increasing head control allows her to actively look at and follow the caregiver, thus turning passive into active behavior.

At the same time, as illustrated by the following vignette, difficulties in one area of development can trigger problems in another:

A toddler who is neither talking nor walking by the expected age is offered a range of services including occupational, physical, and speech therapies. So far this child’s life has been marked by grim hardships. He was born with an impaired intestinal tract that required multiple surgeries and a three-month hospital stay. When he returned home to a family with a history of violence, he was placed in a darkened room. Later he was moved to foster care. He has now been assessed as “developmentally delayed,” but it is important to recognize that many non-physical factors -- including trauma, loss, deprivation, stress, discontinuity of care, and perhaps depression -- are part of the reason why he has been slow to develop.

In considering the interrelatedness of different aspects of development for very young children, it is also worth underscoring a point noted earlier – that children as well as caregivers shape how development unfolds. For example, an infant with cerebral palsy may manifest motor and sensory symptoms – for instance, arching of the back while being held or seeming to avoid face gazing –

that can make it more difficult for the parent to feed, console, or hold her. As a result, the parent may experience feelings of rejection, which, in turn, can have negative implications for parent-infant attachment. This kind of pattern suggests that parents and other caregivers who need more support than would have otherwise been necessary in addressing their children's special physical needs, may benefit from special interventions focused on their relationships with their babies and toddlers.

As will be discussed in more detail later in this report, all too often the institutions and service systems that work with children whose healthy development is compromised are not well structured to take into account – or to take advantage of – the interdependence of physical, cognitive, and social-emotional development. To return to the vignette of the toddler who was neither walking nor talking by the expected age and who was offered occupational, physical, and speech therapies, at first glance, the intervention plan of therapies such as physical and speech therapies seems robust. But in fact, by limiting itself solely to task-oriented therapies, the plan misses important aspects of what this child needs. Notably, it makes no provision for mental health services.

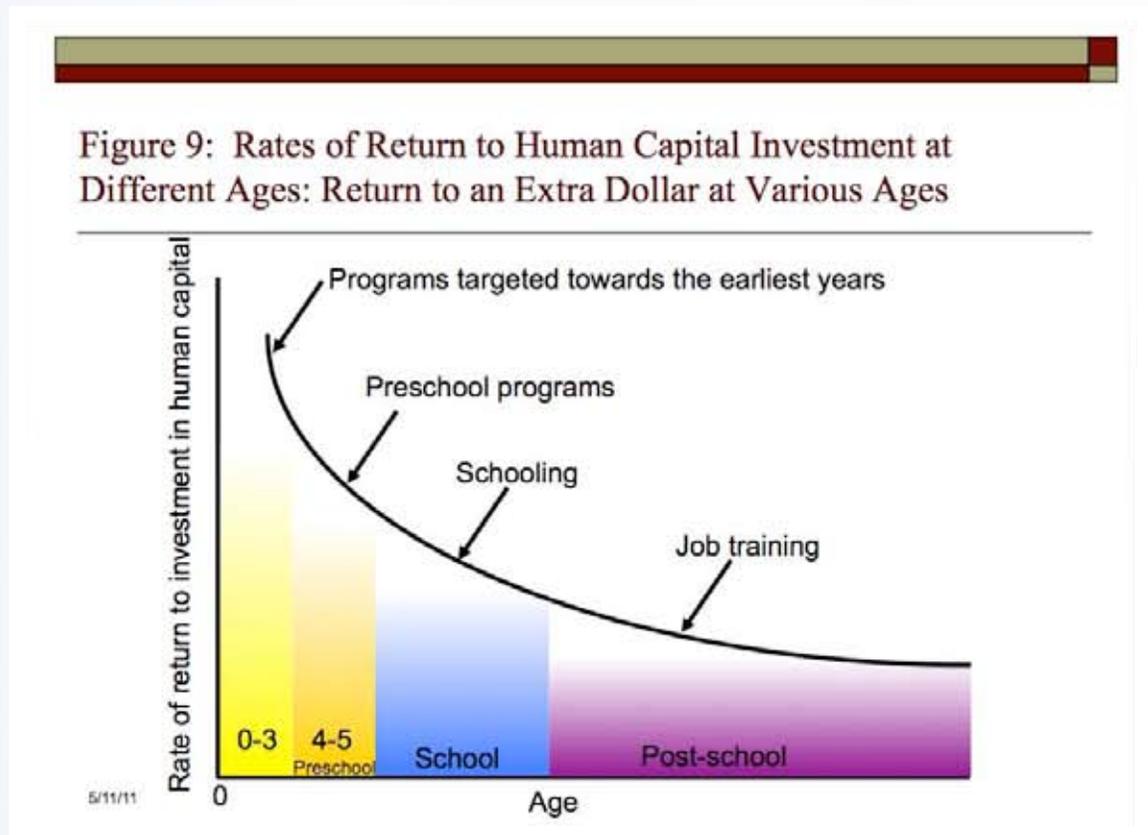
A key reason why mental health services have been overlooked in the treatment plan for this child is that the systems in many states, including New York, that have been set up to recognize and care for disorders in young children are bifurcated, with the division stemming in part from different ways of diagnosing problems. The systems that focus on developmental delays look for physical or neurological problems, while those that address mental health difficulties are concerned with psychological difficulties. In addition, there are funding restrictions with each system reimbursing only what is within their categorical mandate rather than designing a plan that addresses the whole child and his/her family.

## ***There Is a Strong Research-Based Case for Economic Investments in Early Intervention***

Several research studies conducted over the past decade seek to identify the dollar costs and benefits of human-capital investments for our society. The studies have not focused exclusively on the interventions to promote mental health and social-emotional development that are the main concern of this report. But especially in light of researchers' powerful findings on a broader group of programs targeted to young children – including programs that do encompass efforts to promote children's social-emotional well-being – some of these studies are well worth including in an examination of the level of resources that should be devoted to mental health and related services for very young children.

Other research demonstrates that tax dollars spent on efforts to promote early childhood development yield extraordinary returns compared with other investments in the public, and even private, sector. Some of these benefits are gains for the individual children involved, in the form of higher wages later in life. But the broader economy also benefits because compared to similar children who were not exposed to the interventions, on average the children who were involved have higher skill levels that translate into their later becoming more productive members of society (Rolnick & Grunewald 2007). While investing in early education for children of all backgrounds has economic benefits for society, the returns are particularly pronounced for children who live in poverty, with the benefits manifesting themselves as reduced costs associated with more school readiness, higher graduation rates, and in later years, reduced criminal activity and higher levels of employment for both teens and adults (Heckman, 2009).

One important study comes from James Heckman, the Nobel Prize-winning economist, who has calculated the economic rates of return that accrue to society from human-capital investments targeted to various age groups. As shown by the following graph, Heckman finds that the returns on investments in programs for young children are high and that these programs ultimately cost society less than later interventions (Heckman, NAEYC).



Another perspective on the economic benefits of intervening early comes from examining the enormous financial costs imposed on society by child abuse and maltreatment. For example, a study that focused on one state, Ohio, estimates that the annual direct costs of child abuse and maltreatment to Ohio – costs for foster care, law enforcement, judicial activities, and health care -- were \$290 million in 2007 dollars. And at \$2.1 billion, long-term indirect costs to the state – which include estimates of lost earnings potential and lower levels of employment for maltreated children later in life -- were many times higher. Since estimates of long-term costs for the U.S. follow similar patterns -- direct costs of \$33 billion and indirect costs of \$77 billion in 2007 (Wang & Holton, 2007) -- it is very likely that significant costs are incurred when child maltreatment goes undetected or untreated in New York City and State.

### ***III. System-by-System: Challenges, Opportunities, Recommendations***

This section takes a closer-up view of key New York City and State systems that are involved -- and that in many cases could become more involved -- in addressing the mental health needs of young children. For each system discussed, the section provides a brief overview of what the system consists of, an analysis of key challenges and opportunities for the system that shape its capacity

to promote the mental health of young children, and a set of recommendations. Many of the observations about challenges and opportunities facing the systems are based on the knowledge and expertise of members of the Work Group and its advisors, who collectively represent a wide range of systems that serve children and families in New York City and State.

## **Primary Health Care**

### **System Overview**

The primary health care system in New York City and State that affects young children consists of public and private hospitals and their neonatal intensive care units, health clinics, and physicians and other medical settings and practitioners who treat children and their parents or other caregivers.

### **Opportunities and Challenges**

Primary health care settings, which are visited by virtually all families, are an obvious and important venue in which to provide mental health services to young children. Recent estimates suggest that at least 95 percent of U.S. children regularly visit a pediatrician, making the primary health care system the only one to routinely see the vast majority of infants and toddlers before they enroll in school (Newacheck, et al., 2002). With this kind of reach, the system has tremendous potential to offer comprehensive and non-stigmatizing mental health services to young children.

However, few pediatricians and primary health care providers routinely address young children's emotional problems nor do they regularly assess the quality of the parent-child relationship—the chief influence on the child's mental health. A survey of members of the American Academy of Pediatrics (AAP) revealed that pediatricians feel there is a lack of training to identify mental health problems, a lack of time to treat these problems themselves, and a lack of referral options to address these problems within the community (Horwitz, et al, 2007).

In addition, most primary health care providers lack training in the cultural competencies that are often needed to understand and relate to young children in the context of their ethnic backgrounds -- competencies that are enormously important in our diverse city and state. Another important shortcoming of the primary care system is that despite compelling research documenting the seriously negative impact that maternal depression and traumatic stress in mothers have on infants, pediatric primary care clinics do not routinely screen for maternal trauma and depression.

One of most the formidable obstacles to ensuring that children receive mental health services as a routine part of their primary health care is the way that reimbursement practices within New York State Medicaid and managed care plans are structured. Reimbursement rules often make it difficult or impossible for providers to unbundle screening and mental health services from other well-child activities -- and thus difficult for them to receive additional reimbursement when they perform these functions. The President's New Freedom Commission on Mental Health (2003), noting that expanded screening and collaborative care models could save lives, called on the federal government to provide reimbursement for core components of such care, including screening, consultation, and home visits, and to abandon the need for a psychiatric diagnosis for reimbursement.

One sign of progress in professional recognition of the scope of health-related services that should be available to infants and toddlers is that in 2006 the AAP called for routine developmental screening of infants and toddlers at their 9-, 18-, and 30-month well-child visits (American Academy of Pediatrics Council on Children with Disabilities, 2006). This policy statement has since been made more comprehensive by a 2010 recommendation from the AAP Task Force of Mental Health, suggesting that screening for social-emotional problems should also occur, but only after an abnormal developmental or autism screening test or as a result of clinical observation and concerns (Foy, Kelleher & Laraque, 2010).

## **Recommendations**

- Early childhood mental health specialists should be co-located in primary care practices. Key on-site services that could be provided by these specialists include coordination of social-emotional screening programs, developmental and psychological assessments, management of referrals to the Early Intervention system and to services recommended by the Committee on Preschool Special Education (both systems are discussed later in this section), and other appropriate services, and short-term behavioral, developmental, or parenting interventions. It is especially recommended that the specialists create linkages with mental health treatment clinics for young children and adults and with special education services for children aged 0 to 5.
- Funding streams should be structured to adequately reimburse the provision of mental health services in primary care settings. If the kind of change of reimbursement policies called for by the New Freedom Commission on Mental Health is not forthcoming at the federal level, New York State -- if not now, when the state is in the midst of a budget crisis, then whenever the fiscal outlook improves -- should actively explore funding to support this critical initiative. Providers should be incentivized to provide routine developmental and social-emotional screenings in the course of well-baby visits.
- Pediatric providers, residents, and medical students should be educated in ways that will produce a cadre of health care professionals who are trained to recognize the warning signs of mental illness in New York's youngest children and to have a strong awareness of how the cultural practices and beliefs of the families of the young children they treat affect the families' understanding of social and emotional development in their children.
- Building on and moving beyond proposals such as the one cited above to conduct pediatric screenings for mental health problems after an abnormal developmental or autism screening test or as a result of clinical observation, consideration should be given to the option of making such screenings a universal standard for pediatric care. Information from the assessment of a young child's social and emotional development should be embedded in a larger plan of identification, referral, and follow-up.
- Physicians caring for newborns and their mothers should routinely screen for maternal trauma and depression.

## **The New York State Early Intervention Program**

### **System Overview**

The New York State Early Intervention (EI) Program is by far the most comprehensive program focused on finding and treating children birth to age 3 with developmental disabilities and delays. In the program year 2009/2010, 76,144 children were served through the New York State Early Intervention Program. Operated by the state Department of Health Bureau of Early Intervention, the program is part of the federal Early Intervention Program that was authorized under the 1986 Individuals with Disabilities Education Act (IDEA) legislation. The vision of IDEA and EI is that services to infants and toddlers will be multidisciplinary and encompass all domains of development (New York State Department of Health Early Intervention Program; [http://www.health.state.ny.us/community/infants\\_children/early\\_intervention/](http://www.health.state.ny.us/community/infants_children/early_intervention/)).

To be eligible for EI services, children must be under 3 years old and have a confirmed disability or established developmental delay in one or more of the following areas of development; physical, cognitive, communication, social-emotional, and/or adaptive. Eligibility for the program is established through the use of standard scores from norm-referenced instruments (i.e. standard

deviations) and/or through the use of a percentage of delay. The wide variety of services, both center-based and home-based, that EI offers to eligible infants and toddlers with disabilities and their families, include: special education; speech, occupational, and physical therapies; psychological counseling; social work services; service coordination; family training and parent support groups; nutrition and vision services; and assistive technology devices and services.

### **Opportunities and Challenges**

If appropriately targeted and implemented, the IDEA/EI system has the potential to have enormously positive impacts on developmentally disabled infants and toddlers -- including highly positive effects on their social-emotional well-being. Several features of the system give it strong advantages for meeting the social-emotional needs of very young children.

First, the system is unusual among social programs for children in having been developed specifically for infants and toddlers and not simply as a downward extension of service delivery models designed for adults or older children. In addition, EI has a family focus that reflects an understanding that relationships are key to how infants and toddlers develop. Finally, the expectation that specialists across all domains of development will be involved in multidisciplinary EI services acknowledges the complexity of infants and toddlers, the interrelationship of developmental domains, and the need to



take holistic approaches to understanding young children's problems and promoting their well-being.

In practice, however, the IDEA/EI system falls far short of its potential. Notably, in connection with the concerns expressed in this report, the system often fails to fully recognize and give priority to the foundational importance of the social-emotional domain, the co-occurrence of mental health and developmental disorders and in general, the need for a greater integration of early intervention and mental health systems (Foley & Hochman, 2006). Consequently, in New York State, the system misses critical opportunities to address the social-emotional challenges that can have significant impact on young children's healthy development in all domains -- and especially to address these challenges in the context of children's relationships with their parents, caregivers and other significant others.

One major problem in the way the system currently functions is that even though social-emotional development is one of the five domains in which children are evaluated for developmental disabilities and even though delays in this area can under applicable law and regulation determine eligibility for services, it is the view of the committee that it is infrequent that children are found eligible for services where social-emotional difficulties are the sole or primary basis of delay. This raises the question whether these children do not in fact meet eligibility criteria, whether assessment procedures in this domain are less than effective in accurately identifying social-emotional problems in infants and toddlers, or whether the percentage of delay framework reflected in eligibility regulations adequately addresses social-emotional impairment which endangers optimal development.

Similar experiences are reported in national data. That data suggests that infants and toddlers with social-emotional problems may be under identified and under served in the EIP. Only four percent of young children receiving early intervention (EI) services through IDEA Part C are identified as having social-emotional problems by EI providers. Yet, parents of up to 25 percent of children receiving EI services reported that their children were over anxious, hyperactive, exhibited signs of depression and/or problems with social interactions and more than 30 percent of parents of children receiving EI services report problems managing their children's behaviors (Hebbeler, Spiker, Bailery, Scarborough, Mallik, Simeonsson, 2007).

Another problem is that evaluations of children to determine eligibility for EI services do not properly assess their mental health status. Unlike evaluations for preschool special education programs for 3-5 year-old children, EI evaluations do not require a psychological evaluation. And while developmental assessment is required in EI evaluations, these evaluations may be and usually are conducted by educators. Although it is at the discretion of the evaluation coordinator, the referral source, and/or when indicated by a member of the multi-disciplinary team, to include mental health professionals on the evaluation team, they are usually not included. Other professionals in the system often do not have the tools or the expertise needed to properly assess mental health problems. As a result of these practices, there is a risk that mental health concerns are significantly underreported.

Furthermore the percentage-of-delay framework for determining EI eligibility is not an appropriate metric for social-emotional difficulties. The widely accepted and used instruments for measuring social-emotional problems do not report in terms of developmental age or percentage but in terms of the extent of social-emotional impairment. Perhaps the best measure of social-emotional problems is the degree of social-emotional distress based on a risk inventory that measures the extent of variables such as anxiety, stress, and depression relative to healthy norms.

While infants and toddlers from all kinds of backgrounds and circumstances can be referred for evaluations due to social-emotional concerns, young children in two (often overlapping) categories are especially at high risk and are candidates for referral to Early Intervention for an evaluation. The first is children who have suffered trauma. In light of research that documents the devastating impact of chronic stress on brain development and that shows that children with histories of neglect, abuse, separations from parents, or witnessing family violence are at high risk for suffering long-lasting effects on the capacity to learn and to adapt to stressful situations (National Scientific Council on the Developing Child, 2005), the federal Child Abuse Prevention and Treatment Act (CAPTA, 2002) requires that children ages 0 to 3 with substantiated cases of abuse or neglect be referred to the EI system.

The second category is children who are or have been involved with the child welfare system because they: 1) are in foster care; 2) have been referred to the child welfare system but have had cases closed with no mandate for services; 3) are receiving preventive services (child welfare services designed to prevent removal from the home) and/or 4) are under court-ordered supervision. Too often, however, children who have been touched by the child welfare system remain outside the circle of EI services. One problem is that communication and coordination between the child welfare and EI systems is not always as strong as it could be. Also, EI professionals are not necessarily trained to recognize and address the impact of trauma, disruptions in attachment, and other risk factors for social-emotional delays that are prevalent in the child welfare population.

A final problem, alluded to above, is when the EI system does use interventions to address social-emotional problems, those interventions are not necessarily relationship-based.

## **Recommendations**

- EI evaluators, service coordinators, providers, and officials should be trained to recognize and give appropriate weight to social-emotional distress among infants and toddlers.
- As recommended by the national IDEA Infant and Toddler Coordinator Association, mental health / infant mental health professionals should be included on EI evaluation teams, especially when the teams are evaluating children who may exhibit social-emotional delays, who have been exposed to abuse or neglect, who have experienced traumatic separations from their primary caregivers, or who have witnessed family violence or have been exposed to other trauma (Infant and Toddler Coordinator Association, 2004).
- Consideration should be given to requiring psychological evaluations as part of all EI evaluations.
- EI evaluators should be required to use screening tools and procedures that specifically address early social-emotional development. In cases when the determination of this disability is not based on standardized instruments, latitude should be given to have the determination based on informed clinical opinion.
- EI regulations and policy guidance should discontinue the use of a percentage-of-delay framework for assessing social-emotional disability and establish criteria based on normed instruments that assess the degree of social-emotional distress and that are based on a risk

inventory that measures the extent of variables such as anxiety, stress, and depression relative to health norms.

- EI regulations and policy guidance should clearly state that assessments of social-emotional impairment alone can qualify young children for its services.
- Regardless of their disciplines, all professionals in the EI system should use relationship-based and family-focused intervention strategies.
- Stronger efforts should be made to ensure that whenever it is warranted, the EI system provides screening, assessment and — when indicated by assessment results — appropriate services to children who are or have been involved in the child welfare system. To facilitate this process, EI professionals should be trained in recognizing and addressing the impact of trauma, disruptions in attachment, and other risk factors for social-emotional delays that are common among these children. For those children who are receiving preventive services or who are under court-ordered supervision, linkages between EI programs and child welfare agencies should be strengthened to promote better coordination of the services that the EI and child welfare systems provide to these children.
- New EI systems should be developed or existing systems strengthened to ensure that whenever necessary, EI programs are well positioned to make referrals to health, mental health, and other early childhood programs such as the Nurse Family Partnership, Healthy Families, and Early Head Start, that address the mental health needs of high-risk mothers and infants.

## **Early Education Programs**

### **System Overview**

Approximately 221,000 New York City children under age 6 spend most of their waking hours in early child care (Citizens' Committee for Children of New York, Keeping Track of New York City's Children 2010), most of them in publicly funded center-based early education programs. These programs include Head Start, and Early Head Start programs based in centers sponsored by the New York City Administration for Children's Services (ACS), and Universal Prekindergarten programs sponsored by the city's Department of Education (Child Care Inc. Primer). Many community-based early education programs blend funding from the sources just mentioned.

The primary source of services for preschoolers who experience behavior problems or delays in social-emotional development is the Committee on Preschool Special Education (CPSE). This program provides a continuum of services for children between the ages of 3 and 5 who exhibit a significant delay or disability in one or more of the following functional areas: cognitive, language and communicative, adaptive, social-emotional and motor development, if the disability interferes with a child's ability to learn. Children who are judged eligible for CPSE services by CPSE committees are entitled to individualized education programs that follow plans tailored to their specific needs. In 2009, 16,783 New York City children received CPSE services (Keeping Track of New York City's Children 2010).

## ***Opportunities and Challenges***

Early care and education programs, which reach so many young children and work with them for extended time periods, have the potential to provide them with excellent supports for social-emotional growth and to identify and prevent mental health problems at an early stage. Unfortunately many early childhood teachers lack the specialized knowledge and ongoing support needed to operate early childhood programs that are well attuned to children's mental health issues and that are prepared to address those issues by drawing on best practices of the mental health profession.

One key problem is that most early childhood programs have little or no access to early childhood mental health consultants, leaving teachers to struggle with behavior problems and concerns about individual children's mental health. According to one recent study, mental health consultation can reduce the likelihood that children with challenging classroom behaviors will be expelled or suspended. The study found that prekindergarten teachers who have ongoing relationships with classroom-based mental health consultants are about half as likely to report expelling a preschooler as teachers with no such support. Unfortunately, only 23 percent of prekindergarten teachers report having regular classroom access to a mental health consultant (Gilliam, 2008).

In New York State, one encouraging development is that The Children's Plan, developed by the New York State Office of Mental Health (OMH) in 2008 in collaboration with other child serving state agencies, included an American Recovery and Reinvestment Act of 2009 (ARRA) funded initiative to expand mental health consultation to early childhood programs. This demonstration program was a result of an interagency task force that studied mental health consultation and found it to be a promising practice across the nation. Four communities were selected via a competitive process to coordinate multiple partners from mental health, early intervention, child care, early head start and the regional Infant Toddler Resource Centers. Through these consultation services, teachers are given guidance on how to deal with challenging behaviors, and supports are offered to children and families who need additional intervention. An evaluation component will produce first year results in the summer of 2011. At this point in time, project managers are seeking continuation funding in order to sustain these consultative relationships. One year was not sufficient to establish working relationships, improve interagency referral mechanisms and measure results in classroom staff or children.

Another shortcoming of current preschool practice is that programs and caregivers seldom use validated assessment tools such as DECA and Ages and Stages that greatly facilitate identification of social-emotional problems in young children. Similarly, programs often do not make use of evidence-based resources and curricula that focus on promoting social competence and preventing and treating aggression.

The CPSE program could also be a doorway to providing mental health services to young children. But in several respects the program does not serve this function as fully as it could. One shortcoming is that although the CPSE committees that recommend which services children should receive are authorized to offer counseling and training to parents of CPSE-eligible children, the committees rarely include these activities in their recommendations.

Also, as noted, CPSE interventions are designed to focus on how social-emotional issues affect children's ability to learn academically and not on their overall mental health. Despite compelling

evidence that readiness to learn is tied to social-emotional development, CPSE multidisciplinary evaluations to determine whether children should be admitted to preschool special education classes and other services often miss or do not give enough weight to social-emotional factors. One reason why is that often CPSE evaluators are not trained to spot children's social-emotional difficulties.

As just discussed in connection with the CPSE system and as discussed earlier in the subsection devoted to EI services, the EI and CPSE systems often fail to make social-emotional difficulties a focal point of their interventions. Nevertheless, it is very important for teachers in early childhood classrooms to know that children who are assessed with developmental delays can be referred to these systems – both because the systems can and do help families address many aspects of developmental disabilities and because regardless of the current limitations of these systems in the area of social-emotional development, they may provide some assistance with behavioral difficulties. But unfortunately, many preschool teachers are unaware of the existence of EI and CPSE resources. Finally, in considering opportunities and challenges connected with early childhood services, it is useful to focus on groups of young children at especially high risk for social-emotional difficulties. Young children who are homeless or involved in the child welfare system or who have other life circumstances that make them exceptionally vulnerable to mental health problems can greatly benefit from participation in high-quality early childhood programs. Even though, as discussed, early childhood programs often lack the training and resources needed to enable them to address social-emotional problems as fully as they could, high-quality programs are likely to offer a level of support for social-emotional development that might otherwise be unavailable to a very vulnerable child. However, typically the early childhood system does not systematically conduct outreach that focuses on very high-risk children.

## ***Recommendations***

- Both center-based and home-based early childhood programs should use validated standardized screening tools to screen children for social-emotional problems.
- Sponsors of the city's early childhood programs, in partnership with the city's Department of Health and Mental Hygiene, should develop early childhood consultation services that build on the call for more mental health consultation to early childhood programs that was made in the state's Children's Plan. In particular, public and private funders should make significant investments to develop and expand on-site early childhood mental health consultation models.
- Sponsors of the city's early childhood programs should offer early childhood centers and home-based programs sequential, in-depth training on best practices for supporting preschoolers' social-emotional development. Sponsors should consider drawing on training and informational resources available at The Center for the Social and Emotional Foundations for Early Learning, (CSEFEL); <http://www.vanderbilt.edu/csefel/>, an organization that focuses on prevention of social-emotional problems. Another training resource that merits exploration is the Program for Infant-Toddler Caregivers, which has a strong orientation to promoting positive relationships between children and caregivers.
- Early childhood programs should be encouraged to make more use of evidence-based mental health prevention and treatment models and resources. Approaches that can be taken include

using preschool curricula such as Incredible Years and PATHS that aim to promote social competence and prevent and treat aggression, and referring children with chronic behavioral difficulties to intensive, evidence-based treatment programs such as Parent Child Interactive Therapy. (See also the following for discussions of promising preschool mental health prevention programs and interventions: Raver, Jones, Grining, Metzger, Champion, & Sardin, 2008; Domitrovich, Cortes, & Greenberg, 2008).

- CPSE should review its policy of recommending interventions for preschoolers only if their disabilities interfere with their ability to learn, and consider broadening its criteria to give more weight to children who have social-emotional problems that could ultimately affect their learning. To support a broadened policy, efforts should be made to build the capacity of CPSE evaluators to assess social-emotional problems in preschoolers. One important step is that these evaluators should be required to attend trainings to help them build skills in this area.



- CPSE should consider making parent counseling and training a more regular part of its plans for interventions.
- New York City and State early childhood programs and systems should create new outreach strategies or strengthen existing ones to help ensure that children who are homeless, involved in the child welfare system, or have other life circumstances that place them at exceptionally high risk for mental health problems are enrolled in high-quality early childhood programs that promote healthy social-emotional development.
- To complement efforts to help the CPSE and EI systems become more responsive to the social-emotional components of children's developmental disabilities, sponsors of the city's early childhood services should work to ensure that all care providers are aware that they can refer young children with developmental disabilities to these systems.

## ***New York State Mental Health Services***

### ***System Overview***

Article 31 Mental Health Clinics, the mental health clinics that are licensed and regulated by the New York State Office of Mental Health (SOMH), represent a critical entry point -- though not customarily the first entry point -- for young children and families to the mental health service system. These clinics are sustained through Medicaid and third-party billing, as well as state-funded fiscal enhancements. Medicaid reimbursement for mental health services is permitted when a Medicaid-eligible child is diagnosed as having a mental health problem. Although SOMH Article 31 clinics can serve children under the age of 5, there is currently a dearth of trained mental health clinicians and a lack of capacity in these clinics to serve young children.

SOMH's Child and Family Clinic Plus is an initiative that was designed to help with early identification of children's emotional difficulties by providing free voluntary screening for mental health problems in community settings. For children under 5 these settings are defined as Head Start programs and child care centers. Using an RFP process, SOMH selected Article 31 clinics that are currently authorized to offer children and families the program's free screening and reimbursable follow-up treatment services.

When the professionals who conduct the screenings identify emotional difficulties in the child, they reach out to the child and family and provide necessary mental health treatment. To increase accessibility, these services may be conducted either in the home or in the child care setting when possible. Referrals for other services that may be needed are made by clinic staff. Like all Child and Family Clinic Plus service providers, Article 31 agencies that have been selected as providers of the Child and Family Clinic Plus services that are offered in early childhood settings are required to obtain satellite licensing, issued by SOMH's Bureau of Inspection and Certification, for each location where services are provided on a regular and routine basis.

### ***Opportunities and Challenges***

In allowing for mental health screening of all children in a designated setting and treatment of children either in their homes or in specific child care programs, the policy directives on which Child and Family Clinic Plus was built represent a significant advance in efforts to identify and prevent mental illness in children ages 0 to 5. However, there are also several obstacles that make it difficult to realize the program's potential. Key obstacles are:

- Obtaining parental consent for mental health screenings has proven to be a major challenge. Parental reluctance is primarily the result of the stigma associated with mental health problems, and parents are therefore very hesitant to probe for mental health difficulties in their children. Article 31 Clinic Plus providers in child care venues have been considerably more successful in obtaining parental consent for treatment rather than screening when teachers have identified their child's specific behavioral problems in the classroom. Parents' motivation to correct recognized problems often serves to overcome this stigma.
- Even though Medicaid accepts a diagnosis of V 61.20 – which designates a “parent-child problem” and is often the relevant diagnosis for so many early childhood mental health problems – this

diagnosis is not honored by Medicaid managed care programs and commercial insurers. In addition, many managed care companies that do reimburse for accepted Diagnostic and Statistical Manual DSM-IV children's mental health diagnoses will not deem the diagnosis applicable when the child is under age 5.

- Current federal interpretation of Medicaid rules prohibit delivery of clinic services in the home. This is a tremendous barrier to comprehensive, effective treatment for young children and their families. Clinics that had been encouraged, especially via the Clinic Plus rate enhancements, to deliver in-home treatment, are now faced with the reality that Medicaid will no longer reimburse them for off-site services. Although SOMH has expressed interest in locating other monies to continue the practice of home visiting, to date the agency has been unable to do so. Commercial insurance companies also will not reimburse for mental health services that are delivered outside of an office setting—for example, in the home.
- The SOMH licensing process for Article 31 agencies that deliver Child and Family Clinic Plus services in early childhood settings has not been amended in any way to accommodate child care settings, which are typically much smaller than usual satellite clinics. An especially problematic feature of the licensing requirements is that the Article 31 agency that offers services in centers must have specific scheduled hours of operation. Because it is difficult for the agency to commit to a large number of scheduled hours in a setting that serves many fewer people than the typical satellite clinic, this aspect of the regulations does not allow for the necessary flexibility in scheduling both appointments and make-up appointments for families with very young children, who often need to reschedule appointments because of conditions like inclement weather and pediatric illness.
- In New York very limited public funding is dedicated to training clinicians and orienting agencies to the state-of-the-art approaches that should be used to treat emotional difficulties in very young children. As discussed, there is broad consensus among experts in the field that the key to treatment of children ages 0 to 5 is relational therapy. Compounding the problem of few resources for this kind of professional development is that fact that most clinical graduate schools (across disciplines) fail to train their students in relational perspectives or in how to recognize and treat emotional disturbances in very young children. Most are also inadequately trained in early childhood development.

Complicating the current situation in New York State is that the Medicaid reimbursement structure for mental health services is very much a system in flux. In October 2010, SOMH began rate restructuring, and is awaiting federal approval for its finalized version. Additionally, the governor is implementing Medicaid redesign which is projected to put all behavioral health services, including those for the under-5 population, into managed care. Both of these changes will leave providers with less revenue than they currently receive. And without offering details, SOMH has indicated its intention to make major changes to Child and Family Clinic Plus, including the possibility of eliminating the initiative altogether.

## ***Recommendations***

- SOMH should support the early identification of disruptions in social and emotional development in primary care settings, and should support and encourage licensed clinics to partner with primary care providers in ways that lead to better coordination of care and ensure access to specialty mental health services when they are needed.

- Commercial insurers should be required to reimburse accepted DSM diagnoses for children even when the child is under the age of 5 years old, and reimburse for diagnoses listed in the DC: 0-3R Diagnostic manual.
- The existing licensing requirements for satellite facilities should be amended to allow for the necessary scheduling flexibility to feasibly deliver services in these atypical venues.
- A more concerted effort should be made to reduce the stigmas associated with seeking out mental health services for young children. SOMH and public and private institutions in mental health and other relevant fields such as the New York State Education Department, the New York State Department of Health, other city and county agencies, and the American Psychiatric and Psychological Associations should develop vigorous public education campaigns that start by giving the public information about mental health and about how to assure emotional wellness in very young children and that go on to deliver a clear message that stigmas should not keep parents and other caregivers from getting help for mental health problems in these children.
- A much stronger training infrastructure for building professional capacity to address early childhood mental health problems should be developed in New York State as will be addressed later.

## ***Services for Children with Developmental Disabilities***

### ***System Overview***

In New York City, children who have been assessed as having developmental disabilities are eligible for a variety of services that are funded and overseen by the New York State Office For People With Developmental Disabilities (OPWDD) or the Mental Hygiene Division of the New York City Department of Health and Mental Hygiene. To be eligible for OPWDD services, children must be assessed as having a substantial handicap or developmental disability. The OPWDD Eligibility Guidelines can be accessed at the following link: [http://www.opwdd.ny.gov/wt/images/wt\\_advisory\\_guidelines.pdf](http://www.opwdd.ny.gov/wt/images/wt_advisory_guidelines.pdf).

Even though someone must have an established developmental disability to be eligible for OPWDD services, there is some flexibility in eligibility determinations for children between the ages of 0 and 7. Children who have suspected developmental delays or developmental disabilities but whose clinical presentation are not clear cut, and/or who are too young to obtain reliable and valid results on standardized intelligence tests, can be given a Provisional Determination of Eligibility to receive services until a more definitive diagnosis can be reached by age 7, when a permanent determination of eligibility for OPWDD services must be established.

OPWDD provides most direct services for children with developmental disabilities and their families via contracts with a network of government and voluntary providers and nonprofit organizations. One important source of services is Article 16 clinics (authorized under Article 16 of the New York State Mental Hygiene Law), which are licensed and monitored by OPWDD. These clinics offer comprehensive diagnostic evaluations along with a variety of therapeutic and habilitation services (services designed to help children function in society). OPWDD licensed services at the clinic can include counseling and psychotherapeutic services delivered by licensed psychiatrists, psychologists,

social workers and mental health counselors, for the identified child, and his/her parents, siblings or other caregivers -- for example, foster parents -- or in individual, group and/or family therapy formats. OPWDD also funds and authorizes an array of family support services for children with developmental disabilities. These services including case management, respite services for families, parent training, and family reimbursement.

### ***Opportunities and Challenges***

The OPWDD network of funded services available to children with developmental disabilities is clearly an important resource for treating young children with dual diagnoses (developmental disability and mental health or behavioral disorder). One particular asset of this system is that, as discussed, OPWDD has flexibility in determining eligibility for its services for young children.

A significant obstacle to providing mental health services to young children via this system is that Article 16 regulations prohibit billing for a direct service to a child and a collateral service to a parent or other caregiver on the same day. As discussed, best practice for treating mental health difficulties for young children is a relationship-based approach in which the parent or caregiver is a critical therapeutic partner or resource in the treatment plan.

### ***Recommendations***

- Medicaid policy should be changed to permit billing for a direct service and a collateral service on the same day.
- Greater capacity must be developed to meet the mental health and behavioral support services for very young children who have co-existing developmental disabilities and mental health or behavior problems. There is very little availability of services relative to the need. The same is true for family support services, including respite, which is a much needed service for parents and caregivers when children have chronic developmental disabilities accompanied by behavior problems.

### ***Child Welfare Services***

#### ***System Overview***

The child welfare system is responsible for investigating reports of child maltreatment, for determining whether it is safe for children to remain in the care of their parents when allegations of maltreatment have been made, for providing services to families to support parents' ability to safely raise their children, and for finding alternate care for children who are not judged to be safe at home. For very young children, alternate care is typically provided through kinship or non-relative foster care.

In New York State municipal or county social service districts, which are regulated and monitored by the New York State Office of Children and Family Services, provide child protective services at the local level. The New York City Administration for Children's Services (ACS) is the local social service district for New York City's five boroughs. ACS's child welfare system is made up of three main types of services:

- **Protection**

ACS's Division of Child Protection investigates more than 60,000 reports of abuse or maltreatment each year, assesses child safety and makes decisions about removals of children from their homes and/or delivery of services that these children and their families need. In Fiscal Year 2008, DCP staff investigated and worked with 28,412 children ages 0-5, nearly one-third of the 93,930 children reported to be abused or neglected during that period.

- **Prevention**

ACS funds preventive services for families in which there is a risk of abuse or neglect to children, to help avert the need for foster care placement. These services are provided through a combination of directly operated and contracted programs. Through these programs, families receive a wide range of supports designed to make it possible for children to remain safely in their homes. According to the ACS Update for Fiscal Year 2009, preventive agencies served 13,785 families that included 31,752 children (of all ages).

- **Foster Care**

Out-of-home placement is a necessary option for some of New York City's and New York State's most vulnerable children. In New York City, ACS operates the foster care system, and oversees contracts with multiple nonprofit social service organizations to provide services to children in foster care and their families. As of November 2009, there were 5,223 children under age 6 in foster care in New York City.

## ***Mental Health Risks to Children in the Child Welfare System***

Most of the young children involved with the child welfare system have sustained various degrees of trauma. These traumas result from one or more of a series of interrelated factors such as neglect, physical or sexual abuse, parents' or caregivers' mental illness or substance abuse, witnessing violence in their homes and/or injury or fatality of a parent or sibling, or exposure to community violence. In addition, children who are in foster care often have attachment disorders stemming from the neglectful or abusive care they received before they were removed from their homes, and they typically go on to experience severe stress imposed by their removal from familiar caregivers. The lack of a stable attachment figure to help young children cope with these events exacerbates their emotional, behavioral and developmental problems. Consequently, young children who have been victims of neglect or abuse have high rates of emotional and/or behavioral disorders during childhood and problems that persist into their later lives.

Many young children are at risk of re-entering foster care after having been returned to their families. Generally speaking, excluding infants who were adopted, the risk of returning to placement was just under 1 in 3, if the child was reunified. For infants discharged to a (relative) guardian, the reentry rate was closer to 14%. (Fred Wulczyn, Lijun Chen, Linda Collins, et al.,(2011). Moreover, over half the children in foster care suffer from chronic health problems and over half experience developmental delays -- at a rate four to five times that of the general population. Chronic health and developmental problems have an established association with mental health difficulties, and all young children in foster care face a greatly heightened risk of emotional and behavioral problems related to the social problems that resulted in their removal and the stressors imposed by being in foster care (Dicker, Gordon, & Knitzer, 2001).

## ***Opportunities and Challenges***

Clearly the child welfare system is a critical point of entry for infant and early childhood mental health services. One asset of the system is that regulations require that all children 5 years old and under be given a formal developmental screening within 30 days of entering foster care. In addition, a mental health screening, which is to include an assessment of past or presenting trauma symptoms, must be conducted for all children age 2 and older, and for any younger children suspected of having an emotional disability. The fact that assessments of children and families are conducted as a routine result of ACS involvement makes using the system as a gateway to mental health services both a viable possibility and a clinical imperative.

In addition to its required assessments, ACS has a number of other resources and practices that can promote the mental health of young children in the child welfare system. For example, ACS Clinical Consultation Teams are available for consultation on-site within each of the Child Protection Borough Offices. These teams, which include specialists in mental health, substance abuse, and domestic violence and ancillary substance abuse disorder services in key offices, may be called upon to assist in assessments by child protective staff, case conferences, home visits, intervention planning, referrals and training. In another example of useful resources, ACS now holds Family Team Conferences designed to bring families whose children have been removed or where removal is being considered together with relatives, friends and other members of their natural support groups, and with their professional support persons, including therapists, to assess children's safety and well-being and to inform service planning.

The ACS initiative, Improved Outcomes for Children, includes a requirement for Family Team Conferences. Family Team Conferences represent a process for engaging family, community members, foster parents and relative caregivers in critical decisions related to safety, placement, placement preservation, child well-being and permanence.

A Placement Preservation conference, initiated by a ACS contracted Provider Agency or foster parent, needs to be requested before a child(ren) is replaced from one placement to another. This conference is scheduled whenever a provider agency's case planner determines, in conjunction with his/her supervisor (and as appropriate, foster parent), that a child's placement is threatened by a potential disruption. This practice is designed to avoid or minimize the adverse impact of multiple moves on young children's developing sense of security and trust and on their ability to form attachments.

In 2002, the ACS Division of Child Protection developed a "Babies Can't Wait" committee, which consisted of ACS staff and a wide array of community partners who focused on the unique needs and vulnerabilities of infants and toddlers in foster care. Due to shifting priorities within ACS, the committee no longer meets, but during the period when it was active, it developed guidelines for selecting the kind of foster homes for infants that have the potential to become permanent when reunification with parents is not possible. The committee also formulated guidelines both for caseworkers' assessment of infants and toddlers and for family visitation practices for infants in foster care. The guidelines were designed to support successful reunification whenever possible by promoting infants' attachment to parents who are not primary caregivers because their children have been placed in foster care. It is now reported that ACS will reconvene the "Babies Can't Wait" committee in the Fall of 2011. We support the reinstatement of this committee.

ACS preventive services offer a conduit for delivering mental health services to very young children and families. The home visits and monitoring required in preventive programs can promote assessment of the need for mental health interventions and provide referrals to needed services. ACS has recently started to fund new preventive service programs, known as Family Treatment/ Rehabilitation (FT/R) programs, that are built on a new service model. FT/R Programs will provide intense clinical interventions to families in which child abuse or neglect related to the chemical dependency/and or mental illness of an adult or child in the family places a child at risk of removal.

A well-trained clinical staff can help transform these new programs into effective components of a comprehensive model of mental health care for young children and their families.

Notwithstanding the many opportunities to prevent and treat mental health difficulties of young children within ACS, there are many reasons why it is difficult to maximize the system's potential to help:

- Despite the high levels of trauma among young children known to the child welfare system, many ACS staff members who assess and work with families still have too little recognition of the pervasive, adverse impact of trauma on the very young child.
- As noted, the moves of children in foster care from one home to another exacerbate attachment disorders. Despite initiatives within ACS to minimize attachment disruptions, ACS and provider agency staff members level of knowledge of the detrimental impact of loss and attachment disruption on children's social/emotional development remains uneven.
- ACS does not always identify signs and symptoms of mental health disorders and/or developmental disabilities in parents that put children at risk of recurring neglect or abuse and of developing emotional and behavioral problems.
- Mental health screening and assessment of very young children in the child welfare system do not always include the use of standardized screening and assessment measures with established psychometric strengths.
- Although the Clinical Consultation Teams do not provide direct service to children birth to age 5, provision for addressing issues related to early childhood development and mental health are handled by the Medical Services component of ACS in collaboration with Mental Health and other Consultants. The Medical Services component takes the lead in making recommendations for Early Intervention (EI) and child development related needs.
- When preventive and foster care agencies do identify early childhood mental health disorders, the lack of available mental health treatment providers caring for children under the age of 5 makes it a struggle for these agencies to find the treatment these children need. However, these agencies are not required to have linkages with organizations that provide early childhood mental health services – a requirement that might facilitate searches for those resources that are available.
- ACS does not routinely flag the social-emotional and trauma-related needs of young children with substantiated cases of abuse and neglect who are given EI screenings and services, thus

missing opportunities to communicate with the EI system on shared cases in ways that would help both systems address the needs of these high-risk children.

- The primary intervention offered to parents whose children have been removed and placed in foster care is parenting classes. These often consist of didactic presentations on a variety of topics that most often have no theoretical underpinning or empirical support for their efficacy. (Examples of parenting programs that are evidence based are: Infant-Parent Psychotherapy, Child-Parent Psychotherapy, Parent Child Interaction Therapy – PCIT --, Attachment and Bio-Behavioral Catch-Up, Triple P – Positive Parenting Program, Multidimensional Treatment Foster Care for Preschoolers, and Nurturing Parenting Programs. Many of these programs are used widely) (National Registry of Evidence Based Programs and Practice). A related problem with these classes is that they primarily offer general information and do not focus on a particular child or on a particular parent/child relationship.
- The standard used to decide whether parents with children in foster care should be given more contact with their children is whether parents have complied with service plans or completed parenting programs —and not whether there have been observed changes in their parenting, especially improvements in the areas of parenting that generated initial ACS concerns.

## **Recommendations**

- While ACS has made progress in considering attachment difficulties and trauma for children the agency serves, the system needs to place still more emphasis on these serious problems in very young children. Ongoing training about the concepts and principles of trauma and attachment as these relate to very young children should be conducted at all different levels of ACS and its contract agencies, with agency leaders reinforcing the concepts in their daily supervision of line staff.
- Mental health members of each ACS Clinical Consultation Team should be required to have knowledge of principles of early childhood development and early childhood mental health.
- Mental health screening and assessment of very young children in the child welfare system should include the use of standardized screening and assessment measures with established psychometric strengths.
- ACS should resume its work around the implementation of its guiding principles for Parent Education and Support, as well as recommended evidence-based or promising parenting programs to support the ability of birth parents and foster parents to provide nurturing care.
- The standard used to decide if parents with children in foster care will be granted more contact with their children should shift from indications of whether parents have complied with service plans or completed courses. Instead the standard should center on observed positive changes in parenting, especially improvement in the areas that originally generated ACS concern.
- ACS and the EI system should work collaboratively to ensure that particular attention is paid to the social-emotional and trauma-related needs of young children with substantiated cases of abuse and neglect who are given EI screenings and services.

- The Babies Can't Wait Committee should be restored or a similar group within ACS that focuses on the unique needs and special vulnerabilities of infants and toddlers in foster care should be convened.

## ***IV. Training Focused on the Mental Health of Young Children: A Key Issue for All Systems***

As suggested in the previous section, New York City and State need stronger and more concerted training aimed at helping people who work with young children in various systems that are outside of but relevant to the field of mental health to spot and effectively respond to social-emotional difficulties and delays in infants, toddlers, and preschoolers. Too often professionals who are on the front lines of providing services to young children – for example, early childhood teachers, EI service providers, and physicians and nurses — lack the tools and knowledge needed to make the most of their important opportunities to prevent and address mental health difficulties for the 0 to 5 age group.

At the same time, the expertise of professionals working within the mental health field often does not extend to very young children. Not only do many therapists, supervisors, and other workers in the mental health system lack specialized, in-depth knowledge of early childhood development, but in many instances they have not been trained to use the relationship-based approach that should infuse all treatment of infants, toddlers, and preschoolers. Capacity building should include training, consultation, supervision and opportunities for ongoing learning.

It is beyond the scope of this White Paper to present a detailed blueprint for a new or expanded training system that meets the two interrelated sets of needs that have just been discussed. However, as a starting point for further dialogue about how to develop such a system, this section offers suggestions of: 1) guiding principles that could be used to design a more expansive and cohesive training system in New York; 2) key topics that training should cover; and 3) modes of delivering the training.

Suggestions in these three areas were originally designed for training of practitioners within the mental health field. However, even though training of these professionals must be much more intensive and specialized than mental-health training for other fields, the suggestions are offered as possible guides not only for training in the mental health field but also for training focused on managers and practitioners working in related disciplines.

### ***Guiding Principles and Core Values for Early Childhood Mental Health Training***

The following statement of principles and core values is adapted from the New York Zero-to-Three Network Mission Statement (NY Zero to Three, 1999):

High-quality training on social-emotional development and mental health difficulties for very young children should reflect:

- Established principles of adult learning.
- A recognition that diagnosis of mental health difficulties in very young children is fluid because it reflects only a slice in developmental time and an understanding that diagnosis should include an assessment of the relationship of the parent and the young child.

- A recognition of the central role of parents and caregivers in facilitating cross-currents of development and an awareness that a relationship-centered perspective is essential in working with young children.
- An understanding that human growth includes multiple, interrelated lines of development, including neurophysiologic, communicative, sensory-motor, emotional and social development, the formation of cognitive structures, the development of coping and adaptive capacities, and the unfolding of an inner life.
- An appreciation of the cultural diversity of families and the importance of using interventions that are sensitive to different traditions, beliefs and values.

These guiding principles should help planners create training experiences that do justice to the complex realities that are involved in preventing, identifying, and treating mental-health difficulties in young children. However, it is important to recognize that even when individual training sessions and courses reflect these principles, training will fall short of its potential to make a difference unless it is defined as part of sustained organizational capacity-building. Thus, one other important guiding principle for training is that the design and delivery of individual training sessions, courses, and workshops should reflect the assumption that these experiences will be fortified and reinforced by ample opportunities for consultation, supervision, and learning that extends beyond the training period.

### ***Key Topics for Training to Cover***

Two key topics for training to cover are 1) the foundations of early childhood development and 2) the developmental and mental health disorders of infancy and early childhood. It would also be useful for training to help practitioners acquire skills associated with observation and assessment, and the knowledge and skills needed for clinical reasoning. Another important area of training concerns the family – topics such as the structure and nature of training, how family relationships are formed, and pregnancy and parenthood. Finally, training could help trainees understand the community and cultural contexts that help to shape the lives of young children and their families.

### ***Ideas for Modes of Delivering Training***

One possibility for how training could be offered would be as a module or curriculum provided to all relevant staff at a single agency or small group of agencies. Alternatively, training could be conducted regionally – for example, in individual New York boroughs, or in each of the major cities within the state – and offered to trainees across many different agencies. Possibilities for online training and/or other means of distance learning using a well developed curriculum should be explored. Whenever possible, rather than being confined to one or two workshops, training should consist of a more extended set of learning experiences that build upon one another, giving trainees time to assimilate new ideas and approaches. Training should also include reflective supervision.

## ***V. Conclusion: A Call to Action***

A growing body of research makes it clear that many infants, toddlers, and preschoolers suffer from mental health difficulties and that these difficulties should be addressed as early as possible. At the same time, proactive interventions to promote the social-emotional health of very young children can help to ensure they enter school ready to learn and to take important first steps toward productive adulthoods.

The challenge facing New York City and State is to create a cross-system plan to:

- Promote overall early childhood social and emotional wellness,
- Prevent emotional and social illness in children ages 0 to 5, and
- Provide treatment for children in this age group with mental health problems.



This plan would be consistent with the public health framework of promotion, prevention, and intervention that has guided the analysis of this report. Creation of the plan would proceed from the kind of system-by-system examination of current services that has been featured in the report, with the examination focusing both on the assets of these systems and on any counterproductive regulations and practices that impede progress.

Developing the plan starts with the recognition that maximizing social and emotional well-being for children cannot be the sole responsibility of any one system but must emerge from a partnership of all relevant city and state institutions. As discussed, some of that shift in perspectives has already occurred: the earlier edition of this White Paper helped to stimulate valuable cross-systems dialogues and changes in policy and practice. However, more must be done to develop and sustain a mature partnership dedicated to the kind of innovation that is called for.

One of the top priorities of a new partnership should be the creation of a cohesive training system that prepares managers and staff members in all systems that serve children and families to attend to the social-emotional needs of children younger than 5. Another important theme that emerges from this report is that delivery of mental health services should not be confined to mental health clinics and the offices of therapists. Services should also be offered in child care programs, in the home and in other settings that are convenient to families, making it much more likely that help will reach a high proportion of the children and parents who will benefit from assistance. Finally, as stressed throughout this report, the critical impact of relationships on virtually all aspects of the development of young children makes it imperative that mental health interventions for this age group be relationship-based.

Building the model of care that has just been described depends on strong leadership. The New York City Early Childhood Mental Health Strategic Work Group stands ready to continue its role as catalyst, helping to set priorities and design strategies. The Work Group is confident that drawing on the skills, knowledge and sensitivity of professionals and other workers in many systems, New York City and State can create a continuum of care that fortifies the social and emotional health of our youngest children.

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